Supreme Court, U. S.
FILED
JUL 25 1974
MICHAEL RODAK, JR., CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1973

NO. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

PETITION FOR A WRIT OF CERTIORARI TO
THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

ROBERT L. SHEVIN
Attorney General

DANIEL S. DEARING
Chief Trial Counsel

RAYMOND W. GEAREY
Assistant Attorney General

The Capitol
Tallahassee, Florida 32304

SUBJECT INDEX

	Page
Opinion Below	1
Jurisdiction.	1
Questions Presented	2
Constitutional Provisions Involved.	2
Statutory Provisions Involved.	3
Statement of the Case	4
Reasons for Granting the Writ . .	14
Conclusion.	45

TABLE OF AUTHORITIES

Cases

Anonymous, People ex rel v. LaBurt, 369 U.S. 428 (1962). . . 11

Anonymous, People ex rel v. LaBurt, 385 U.S. 936 (1966). . . 11

Beverly's Case, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603) . . 16

Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D. Ga. 1972), appeal docketed, No. 72-3110 (5th Cir. 10/4/72) . 23

Collins v. Hardyman, 341 U.S. 651 (1951). 34

Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973). . 39

Donaldson, In re, 364 U.S. 808 (1960). 11

Donaldson v. Florida, 371 U.S. 806 (1963). 11

Donaldson v. O'Connor, 390 U.S. 971 (1968). 11

Donaldson v. O'Connor, 400 U.S. 869 (1970). 11

Eslinger v. Thomas, 476 F.2d 225 (4th Cir. 1973) . . 39

TABLE OF AUTHORITIES

Cases (Cont.)

Fleming v. Adams, 377 F.2d 975, 977 (10th Cir. 1967); cert. den. 389 U.S. 898 (1967). 35

Fullington v. Shea, 320 F.Supp. 500 (D.Colo. 1970), affirmed 404 U.S. 963 (1970). 34

Greenwood v. United States, 350 U.S. 366 (1956). 28

Hammer v. Rosen, 7 App.Div. 2d 216, 181 N.Y. S. 2d 805 (1959) . 30

Hoffman v. Halden, 268 F.2d 280 (9th Cir. 1959) . . 40

Humphrey v. Cady, 405 U.S. 504 (1972). 14

Jacobson v. Massachusetts, 197 U.S. 11 (1905) 33

Lake v. Cameron, 124 U.S.App.D.C. 264, 364 F.2d 657, 663 (1966). . 25

McGowan v. Maryland, 366 U.S. 420 (1961). 34

McKinney v. DeBord, 324 F.Supp. 928 (E.D.Cal. 1970). 39

Niklaus v. Simmons, 196 F.Supp. 691 (D.Neb. 1961). . 34

Oakes, In re Josiah, 8 L.Rep. 123 (1845-46) 18

TABLE OF AUTHORITIES

Cases (Cont.)

Ogden v. Saunders,
12 Wheat. 213, 281-82 (1827) . . 43

Penn Dairies v. Milk Control
Commission, 318 U.S. 261 (1943). 33

Pierson v. Ray,
386 U.S. 547, 555-557
(1967. . . . . 39, 40

Prince v. Massachusetts,
321 U.S. 158 (1944). 33

Rouse v. Cameron, 373 F.2d 451,
457, n. 30 (D.C. Cir. 1966)
. . . . . 22, 23, 28, 30, 35, 44

Skinner v. Spellman,
480 F.2d 539 (4th Cir. 1973) . . 39

Smith v. Clapp, 436 F.2d 590,
(3rd Cir. 1970). 31

Southern Pacific R.R. Co. v.
United States, 189 U.S. 447,
450 (1903) 39

Stachulak v. Coughlin,
364 F.Supp. 686 (N.D. Ill. 1973) 23

Stephens, United States ex rel v.
LaBurt, 373 U.S. 928 (1963). . . 11

Taylor v. Perini,
365 F.Supp. 557 (N.D.Ohio 1972). 39

TABLE OF AUTHORITIES

Cases (Cont.)

United States v. Klein,
325 F.2d 283, 286 (2nd Cir. 1963). 27

Welsch v. Likins,
373 F.Supp. 487 (D.Minn. 1974) . . 23

Westberry v. Fisher,
309 F.Supp. 12 (D.Me. 1970). . . . 39

Wyatt v. Stickney, 325 F.Supp. 781
(M.D.Ala. 1971), on submission
of proposed standards, 334 F.Supp.
1341, enforced, 344 F.Supp. 373,
387, Appeal docketed sub non,
Wyatt v. Aderhold, No. 72-2634
(5th Cir. 8/1/73). 23, 26, 44

United States Constitution

Amendment XIV, §1. 2

Federal Statutes

28 U.S.C. §1254(1) 2

28 U.S.C. §1343(3) 3, 12, 34

28 U.S.C. §§2281, 2284 12

42 U.S.C. §1983. . . . . 3, 12, 34, 39

TABLE OF AUTHORITIES

State Statutes and Codes

§47.30.130, Alaska Statutes (1969 Supp.) 42

§7104, California Wel. & Inst. Code (1969 Supp.). 42, 43

Law Reviews, Books and Articles

American Psychiatric Association, A Position Statement in the Question of Treatment, 123 Am.J. Psychiatry 1458, 1459, 1460 (1967) 29

Bazelon, Implementing the Right to Treatment, 36 U.Chi.L.Rev. 742 (1969) 28

Birnbaum, A Rationale for the Right, 57 Geo.L.J. 752 (1969). . 37

Birnbaum, Some Remarks on the Right to Treatment, 23 Ala.L.Rev. 623, 235-636 (1971). 10, 37

1 W. Blackstone, Commentaries, 303-307 (9th ed. 1783) 16

Cameron, Nonmedical Judgment of Medical Matters, 57 Geo.L.J. 716 (1969) 24, 42

TABLE OF AUTHORITIES

Law Reviews, Books and Articles (cont.)

J. Frank, Persuasion and Healing -- A Comparative Study of Psychotherapy (1961) 42

Halpern, A Practicing Lawyer Views the Right to Treatment, 57 Geo.L.J. 782, 786-787, n. 19, 801 (1969) 41, 43

Holmes, Uncollected Letters, 66. 43

J. Katz, Psychoanalysis, Psychiatry and Law, 728-751 (1967) 30

Katz, The Right to Treatment -- An Enchanting Legal Fiction? 36 U. of Chi. L.R. 755 (1969). 24, 43

M. Levine, Psychotherapy in Medical Practice 17-19 (1942). . 24

A. Miles, An Introduction to Public Welfare, 79 (1949). . . . 17

Miller, Cases and Materials on Criminal Justice, Administration and Related Processes -- The Mental Health Process, 1663 (1971).42

TABLE OF AUTHORITIES

Law Reviews, Books and Articles (Cont.)

Note, Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right, 32 Md.L.Rev. 42 (1972) 24

Note, The Nascent Right to Treatment, 53 Va.L.Rev. 1134, 1140 (1967). 19, 43

2F. Pollack, The History of English Law (2nd ed. 1911) . . . 16

Reisner, Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends . 31

Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich.L.Rev. 945 (1959) 19

Szasz, The Right to Health, 57 Geo.L.J. 734, 741, 743 (1969) 25

Szasz, The Right to Psychiatric Treatment: Rhetoric and Reality, 57 L.J. 740 (1969) 24

I Winthrops Journal, p. 144, Reprinted in the History of New England 1630-1649, by the Massachusetts Historical Society. 17

TABLE OF AUTHORITIES

Law Reviews, Books and Articles (Cont.)

G. Zolborg, A History of Medical Psychology (1941). . . . 19

1-4, Current Psychiatric Therapies, (J. Masserman ed. 1961-64) 24

5 Records of the Governor and Company of the Massachusetts Bay in New England 80 (1854). 17

Civil Commitment of the Mentally Ill: Theories and Procedures 79 Harv.L.Rev. 1288 (1966) . . . 19

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1973

No.

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

The Petitioner, J. B. O'Connor, M. D., respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Fifth Circuit entered in the above case on April 26, 1974.

Opinion Below

The Opinion of the Court of Appeals is reported at 493 F.2d 507. No opinion was rendered by the District Court for the Northern District of Florida.

Jurisdiction

The opinion and judgment of the Court of Appeals for the Fifth Circuit were entered on April 26, 1974, and copies

thereof are appended to this Petition in the Appendix. This Petition was filed within ninety days of the above date. The jurisdiction of this Court is invoked under 28 U.S.C. §1254(1).

Questions Presented

(1) Whether there is a constitutional right to treatment for persons involuntarily committed to a state mental hospital.

(2) Whether, assuming there is a constitutional right to treatment, staff members at a state mental hospital are liable for monetary damages in a suit under the civil rights act.

(3) Whether, assuming there is a constitutional right to treatment, the patient in this case waived that right.

Constitutional Provisions Involved

Constitution of the United States of America, Amendment XIV, §1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State

> shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States; nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny to any person within its jurisdiction the equal protection of the laws.

Statutory Provisions Involved

42 U.S.C. §1983:

> Every person, who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

28 U.S.C. §1343(3):

> To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured

by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States.

Statement of the Case

Kenneth Donaldson, the Respondent, was involuntarily committed to the Florida State Hospital, Chattahoochee, Florida, on January 3, 1957, by a county court judge of Pinellas County, Florida, pursuant to Chapter 394, Florida Statutes. The commitment order stated his incompetency was due to paranoid schizophrenia with auditory and visual hallucinations and delusions. The order further stated that Donaldson, age 50, a resident of four years, required restraint to prevent self-injury or violence to others. Two physicians served as the investigating committee for the proceedings.

Prior to the Florida commitment, Donaldson had been a patient at Marcy State Hospital in New York from March 12, 1943, to June 26, 1943. At that time, his problems were described as auditory hallucinations, ideas of reference, and delusions of persecution. The medical description was Dementia Praecox, Paranoid Type, presently called Schizophrenic Reaction, Paranoid Type.

In January, 1957, at the time of his admission to Florida State Hospital,

Donaldson was examined by a Dr. Clark Adair. The examination revealed that Donaldson expressed delusions of persecution for which he blamed "rich Republicans" and believed that the "Foreign Policy Association" had attempted to poison him by placing chemicals in his food. The diagnosis was Schizophrenia, Paranoid Type.

At the time of his admission, Donaldson, a Christian Scientist, requested that no medicine or shock therapy be administered and he consistently refused repeated offers of such forms of therapy during his commitment. In addition, he frequently refused offers of other non-medical forms of therapy as well.

At the time Donaldson was admitted to the hospital in 1957, the Petitioner, Dr. O'Connor, was Assistant Clinical Director. He was in charge of the ward where Donaldson was assigned upon admission. In that position, Dr. O'Connor was Donaldson's attending physician. Dr. Gumanis, a co-defendant below, was a staff physician.

On July 1, 1959, Dr. O'Connor became Clinical Director of the hospital, and later that year, Dr. Gumanis succeeded him as Donaldson's attending physician. Dr. O'Connor was subsequently promoted to Superintendent of the hospital on July 30, 1963, and served in that capacity until he retired February 1, 1971. Dr. Gumanis served as Donaldson's attending physician until April 18, 1967. At that time, Dr. Israel Hanenson became Donaldson's attending physician until Dr. Hanenson's death in the fall of 1970.

From that time until his release on July 31, 1971, Donaldson was treated by Dr. Jesus Rodriquez.

In 1959, Florida State Hospital at Chattahoochee provided services for 1,736,540 patient days per year. In 1970, Florida State Hospital provided services for 1,351,000 patient days per year, compared to 21,790 patient days in the psychiatric section of one of Florida's largest, non-government hospitals, Tampa General Hospital, for the fiscal year 1967-1968.

During Mr. Donaldson's assignment to Department A of Florida State Hospital, there were two doctors available; making a doctor patient ratio, at times, of 560/1000 patients for each doctor. In 1960, two doctors were responsible for 1000 patients. Previously, only one doctor had this responsibility. During Donaldson's stay in Department C of the hospital, there was one physician and one psychiatrist for approximately 800 patients.

In 1970, Florida State Hospital provided services for 1,351,000 patient days per year with a staff of 17 psychiatrists, seven physicians, and four psychologists, a total of 28 legislatively approved treating-type positions. Only 50% of each doctor's time was available for psychiatry. The remainder had to be devoted to medical matters and administration.

The American Psychological Association describes the optimum doctor-patient ratio

to be one psychiatrist for each 50 acutely ill patients and one psychiatrist for each 125 chronically ill patients. There were approximately 200-500 acutely ill patients alone at Florida State Hospital during the time in question here.

Throughout the time Dr. O'Connor was Donaldson's attending physician, Donaldson continued to refuse to receive medication and shock treatment due to religious views. It should be noted that a prior exposure to such treatment in New York had been somewhat successful. This refusal continued when Dr. Gumanis assumed responsibility in 1959. During the approximately six and one-half years Donaldson was in Dr. Gumanis' care, written notes indicate he had consultation with staff doctors at least 51 times. Testimony at trial indicated that many other consultations probably occurred, but were not recorded.

Psychological examinations conducted in 1960 and 1961 showed no significant change from previous findings of incompetancy. During June, 1963, Helping Hands, a Minneapolis group, requested information about Donaldson and sought his release. Dr. Gumanis and Dr. O'Connor denied the suggested release because Donaldson continued to require strict supervision. Psychological tests administered in 1964 continued to show no significant changes in Donaldson's condition. An earlier test, scheduled late in 1963, had been refused by Donaldson.

During January, 1964, a meeting of nine members of the staff recommended

continued hospitalization. The written opinion of the staff, issued following the meeting with Donaldson, found him dangerous to others and recommended further hospitalization. Donaldson complained to a member of the state legislature who subsequently arranged an interview and examination by an independent psychiatrist, Dr. Franklin J. Calhoun. Dr. Calhoun concluded:

> That the results of my examination were in complete accord with the diagnostic evaluation of the hospital staff. This man has the type of mental illness that is most difficult for lay persons to detect. Even a psychologist or psychiatrist could be 'fooled' by Mr. Donaldson unless certain types of psychological tests are included in the evaluation. Unless his condition has greatly improved since my examination, I still feel very strongly that Mr. Donaldson is ill, dangerous to society, and should remain hospitalized.

During the summer of 1964, a Mr. John Lembcke, a certified public accountant, in Binghamton, New York, and a former classmate of Donaldson's at Syracuse University in the 1920's, began seeking Donaldson's release. Mr. Lembcke made four attempts between 1964 and 1968 to obtain Donaldson's release. All requests for release were denied due to the opinion of the staff that Donaldson was

dangerous to himself and others, and required strict supervision and treatment which they believed Mr. Lembecke would be unable to provide.

During 1966, Donaldson again refused a psychological examination and continued to refuse traditional forms of medication and shock therapy, but did participate in mileau therapy, religious therapy and recreational therapy.

On April 18, 1967, Donaldson was placed under the care of Dr. Hanenson who ordered another set of psychological tests. The examination, conducted July 13, 1967, showed no significant improvement in Donaldson's condition. Dr. Hanenson ordered another test sequence on March 13, 1968, at which time Donaldson showed the first signs of improvement since 1957. Possible trial visits were suggested. On March 21, 1968, Dr. Hanenson presented Donaldson to a staff meeting. The staff found improvement in his condition and suggested trial visits. Although Donaldson was approved for trial visits, Dr. O'Connor rejected Mr. Lembcke's suggestions of a complete release.

On September 9, 1968, Donaldson was given to a work assignment and granted grounds privileges. Testing conducted during November, 1969, indicated release at an early date. A report was submitted to Dr. O'Connor on February 6, 1970, and another, summarizing all psychological testing was submitted on March 27, 1970. Another physician, Dr. F. D. Walls,

examined Donaldson and reported unfavorably on March 27, 1970. During the fall of 1970, at the death of Dr. Hanenson, Dr. Jesus Rodriquez assumed the position of Donaldson's attending physician. He evaluated Donaldson and noted that he had again refused to work, had refused group therapy and refused other suggested forms of therapy.

On March 4, 1971, Donaldson was again assigned to a general routine work assignment. On July 1, 1971, Dr. Milton J. Hirshberg assumed the post of Superintendent of Florida State Hospital. He examined Donaldson on July 26, 1971, and declared him to be a schizophrenic, paranoid type, in remission and recommended his release. Kenneth Donaldson was released from Florida State Hospital on July 31, 1971.

Prior to the present case, Kenneth Donaldson had brought fifteen separate petitions for a writ of habeas corpus in the state courts of Florida and lower federal courts.[1] All petitions were unsuccessful and on four occasions Donaldson petitioned this Court for a writ of certiorari.

The series began in 1960 when the Florida Supreme Court denied a writ of habeas corpus refusing to openly state whether there is, or is not, a constitutional right to treatment. This Court

---

[1] Birnbaum, Some Remarks on the Right to Treatment, 23 Ala.L.Rev. 623, 635-636 (1971).

denied certiorari. In re Donaldson, 364 U.S. 808 (1960). Similar denials of a writ of habeas corpus were also brought before this Court in 1963. and 1968. Donaldson v. Florida, 371 U.S. 806 (1963); Donaldson v. O'Connor, 390 U.S. 971 (1968).

In 1970, Donaldson, represented by counsel, again sought review of his case. Certiorari was again denied. Donaldson v. O'Connor, 400 U.S. 869 (1970). During this same period, at least three other cases in which various courts had refused to rule on the issue of whether there exists a constitutional right to treatment were brought before this Court. In each case, certiorari was denied. People ex rel Anonymous v. LaBurt, 385 U.S. 936 (1966); United States ex rel Stephens v. LaBurt, 373 U.S. 928 (1963); People ex rel Anonymous v. LaBurt, 369 U.S. 428 (1962).

This suit was initiated in the District Court for the Northern District of Florida prior to Donaldson's release on July 31, 1971. The initial complaint was styled a class action on behalf of all patients in Department C of the Hospital. In addition to damages, for Donaldson and the class, the complaint sought habeas corpus relief as to Donaldson and the class, and injunctive relief requiring the hospital to provide adequate treatment. After Donaldson's release, the District Court dismissed the case as to the class action allegations, and the first amended complaint was filed on August 30, 1971. The amended complaint

sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. Jurisdiction was alleged pursuant to 42 U.S.C. §1983, 28 U.S.C. §1343(3), and 28 U.S.C. §§ 2281, 2284. The amended complaint also asked the district court to convene a three-judge court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30, however, the plaintiff in a memorandum brief, abandoned the prayer that a three-judge court be convened. The prayers for injunctive and declaratory relief were eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward Plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights." The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson

against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionally limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization." Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on that verdict, Gumanis and O'Connor separately appealed to the United States Court of Appeals for the Fifth Circuit. The Judgment of the District Court was affirmed on April 26, 1974. Appellant Gumanis filed a timely Motion for Rehearing which had not been ruled on by the Court as of the time this Petition was filed.

Reasons for Granting the Writ

I

CERTIORARI SHOULD BE GRANTED TO DECIDE WHETHER THERE IS A CONSTITUTIONAL RIGHT TO TREATMENT FOR PERSONS INVOLUNTARILY COMMITTED TO STATE MENTAL HOSPITALS.

The Court of Appeals held that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition. The Court of Appeals found that civil commitment entails a "massive curtailment of liberty" in the constitutional sense, citing Humphrey v. Cady, 405 U.S. 504 (1972), and noted that the due process clause of the Fourteenth Amendment to the United States Constitution guarantees a right to treatment upon a two-part theory.

The first part of the theory is concerned with the rationale for confinement. In its discussion, the Court of Appeals noted that three distinct grounds are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care," "custody," or "supervision." The Court placed these grounds into two categories; one a "police power" rationale for confinement, the other a "parens patriae"

rationale. Danger to others was considered a "police power" rationale; need for care or treatment a "parens patriae" rationale; and danger to self as an area combining elements of both. The Court reasoned that where, as in Donaldson's case, the basis for confinement evokes the parens patriae rationale, that the patient is in need of treatment, the due process clause requires that the deprivation of liberty brought on by commitment be accompanied by treatment. It was this theory the Court applied in this case although there was considerable evidence that numerous physicians felt Donaldson was dangerous to himself and others, which would bring elements of the police power rationale into consideration.

The second part of the theory is concerned with the traditional limitations on a government's right to confine -- that confinement be in retribution for a specific offense; that it be limited to a fixed term; and that it follow a proceeding where fundamental due process safeguards are present. Ignoring the due process protections inherent in the initial commitment hearing, the Court of Appeals found that where such limitations are absent, such as in an involuntary civil commitment to a state mental hospital, there must be a quid pro quo extended by the government to justify confinement. The Court then noted that the quid pro quo most commonly recognized is the provision of rehabilitative treatment.

A discussion of whether there exists a constitutional right to treatment requires a brief examination of the historical basis for involuntary hospitalization of the mentally ill.

In 1603, Lord Coke described the law of insanity as it had developed in England and discussed the Statute de Praerogation Regis, which explicated the King's authority over the property of the mentally ill and outlined the King's duty to care for them in Beverly's Case, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603). Later, during the Eighteenth century, confinement was a privilege reserved for the more affluent. According to Blackstone, one applied for confinement when the disorder was regarded as permanent and the individual could afford the cost of such confinement.[2]

During the Colonial period in the United States, families were expected to care for the mentally ill. In the absence of family the colonial community would not provide care, but would attempt to send the individual back to where he or she came from. In Governor Winthrop's Journal, it is reported that on December 11, 1634, "[o]ne Abigail Gifford, sent by ship into this country, and being found to be somewhat distracted, and a very burdensome woman, the governor

---

[2] 1 W. Blackstone, Commentaries, 303-07 (9th ed. 1783); 2 F. Pollack & F. Maitland, The History of English Law (2nd ed. 1911).

returned her back by warrant to the same parrish, in the ship Rebecca."[3] Some years later, the Massachusetts Bay Company enacted legislation for the detention of violent persons so "that they do not damnify others,"[4] the rationale being that if the individual was a threat to the community, the community could act accordingly.

The emergence of the idea of danger within the purview of organized medicine appears to have been accomplished in 1769 when the first institution for the insane was opened at Williamsburg, Virginia. The chartering act made specific reference to the need for restraining those "who may be dangerous to society."[5] The community's role in providing for the violent and insane who could not be maintained properly by their families was clearly established at that early time. The emphasis

---

[3] I Winthrop's Journal, p. 144, Reprinted in the History of New England 1630-1649, by the Massachusetts Historical Society.

[4] 5 Records of the Governor and Company of the Massachusetts Bay in New England 80 (1854).

[5] A. Miles, An Introduction to Public Welfare 79 (1949).

remained on detention, rather than treatment.

Detention was apparently rarely challenged in the early days of our nation. One of the first cases was brought in 1845 when Josiah Oakes petitioned the Massachusetts Supreme Court by writ of habeas corpus to determine the legality of his confinement. In re Josiah Oakes, 8 L.Rep. 123 (1845-46). Although the attending physician could not predict with any degree of certainty that Oakes would indeed engage in a dangerous act were he not confined, the Court relied on the possibility of danger as a decisive factor against him. The Court ruled that restraint was permissible because "the right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those who goings at large would be dangerous to themselves and others." The Court further states:

> The necessity which creates the law, creates the limitations of the law. The question must then arise in each particular case, whether a patient's own safety or that of others requires that he should be maintained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. That is the limitation and the proper limitation.

The basis of a state's right to confine mentally ill persons against their will rests upon the dual reasons of (1) the power of the state in its role of parens patriae, and (2) its duty to protect under the police power.[6] A state has an obvious interest in the safety of all citizens and the maintenance of a healthy and productive citizenry. It might be argued that the parens patriae theory alone cannot justify confinement without benefit to or treatment of the individual,[7] but it cannot be reasonably or responsibly argued that society does not have the right to confine mentally ill persons with a propensity for dangerous behavior, with or without accompanying treatment.

Treatment, as a goal of confinement of mentally ill persons, emerged with the development of psychiatry as a medical specialty and the successful development of drug and shock therapy during the first half of this century. At this point, the states began to provide such care as was possible within the limitations of state resources.[8]

---

[6] Ross, Commitment of the Mentally Ill: Problems of Law and Policy, 57 Mich.L.Rev. 945 (1959).

Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 79 Harv.L. Rev. 1288 (1966).

[7] Note, The Nascent Right & Treatment, 53 Va.L.Rev. 1134 (1967).

[8] G. Zolborg, A History of Medical Psychology (1941).

The idea that there exists a constitutional right to treatment for the involuntarily committed mental patient was first announced in 1960 in an editorial in the American Bar Association Journal.[9] The editorial had as its impetus an article of Dr. Morton Birnbaum, of the New York Bar, appearing in the same issue.[10]

In his initial article, Dr. Birnbaum suggested the need for recognition of a right to treatment and based his suggestion on the realization that care in state mental hospitals is often substandard. Dr. Birnbaum recognized that inadequate treatment does not often result from individual action by the medical staff, but from inadequate legislative funding:

> As the law has not recognized this right, the state can, and generally does, compel the public mental institution to give inadequate medical treatment to its inmates. The state does this: (A) by compelling the institutionalization of those persons whom it considers to be sufficiently mentally ill to require institutionalization for care and treatment;

---

[9] Editorial, A New Right, 46 A.B.A.J. 516 (1960).

[10] Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960).

> and, (B) by not appropriating sufficient funds to enable the public mental institution to obtain the number of competent personnel and to maintain the adequate physical plant that is necessary to provide therapeutic, rather than custodial, care for these sick people.
>
> * * *
>
> In too many cases, the efficacy of modern medicine is dependent upon a legislative decision rather than upon medical knowledge. If the legislature appropriates sufficient funds to enable the public mental institution to provide proper medical care, the effect of institutionalization is decided to a great extent by the limitations of medical knowledge. If the legislature appropriates insufficient funds, the effect of institutionalization is decided to a great extent by legislative fiat.

The article further suggests that assuming recognition of a right to treatment, that the proper form of remedy would be release, pursuant to habeas corpus proceedings, for those receiving inadequate care. It was thought that the prospect of wide-scale release of mentally ill persons would force the states to either provide adequate care or abandon public mental health institutions altogether. Dr.

Birnbaum noted the obvious threat to the health and welfare of the general citizenry and patients, but felt that such action was justified by the eventual improvement of public institutions.

At the conclusion of his article, Dr. Birnbaum noted several problems with the recognition and enforcement of a right to treatment. The most important of these was the practical realization that in order to avoid the problem of wide-scale release of mentally ill persons and other injustices, that the courts should provide a reasonable interim period between recognition of the right and enforcement of the right.

There is no judicial recognition of a constitutional right to treatment for several years following Dr. Birnbaum's suggestion of such a right. In 1966, the Court of Appeals for the District of Columbia held in Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966), that a patient committed involuntarily to a mental hospital under a District of Columbia Statute had a statutory right to treatment pursuant to the District of Columbia 1964 Hospitalization of the Mentally Ill Act.[11] In addition, Judge Bazelon, writing for the majority, stated that, even absent such a statute, forced confinement in a public mental hospital without treatment might violate either the

---

11 D. C. Code Ann. §21-562 (1967).

due process clause, the equal protection clause, or the Eighth Amendment. Since the decision in Rouse v. Cameron, supra, two District Courts have held that there is a right to treatment for civilly committed mentally ill persons.[12] A third District Court has completely rejected the theory as unworkable.[13] A fourth case has recently extended a right to treatment to civilly committed mentally retarded persons.[14]

However [illegible]ractive the theory of a right to psychiatric treatment may be to all persons concerned with the preservation of individual liberties,

---

12 Stachulak v. Coughlin, 364 F.Supp. 686 (N.D.Ill. 1973); Wyatt v. Stickney, 325 F.Supp. 781 (M.D.Ala. 1971), on submission of proposed standards, 334 F.Supp. 1341, enforced, 344 F.Supp. 373, 387, Appeal docketed sub non, Wyatt v. Aderhold, No. 72-2634 (5th Cir. 8/1/73).

13 Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D.Ga. 1972), appeal docket, No. 72-3110 (5th Cir. 10/4/72).

14 Welsch v. Likins, 373 F.Supp. 487 (D.Minn. 1974).

serious problems arise from the attempted application and enforcement of such a right. These problems are of both a legal and medical nature and have been the subject of considerable commentary.[15]

The overriding problem in defining and applying a right to treatment lies in the problem of judges and juries untrained in medicine and the highly specialized field of psychiatry attempting to second guess the judgment of trained physicians and psychologists concerning what constitutes "adequate treatment."

As early as 1942, over forty (40) distinct methods of psychotherapy were accepted by the medical profession.[16] These methods listed by Levine range from active physical treatment such as

---

15 Szasz, The Right to Psychiatric Treatment: Rhetoric and Reality, 57 Geo.L.J. 740 (1969); Cameron, Non-Medical Judgment of Medical Matters, 57 Geo.L.J. 716 (1969); Note, Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right, 32 Md.L.Rev. 42 (1972); Katz, The Right to Treatment--An Enchanting Legal Fiction, 36 U. of Chi. L.R. 755 (1969).

16 M. Levine, Psychotherapy in Medical Practice, 17-19 (1942). 1-4, Current Psychiatric Therapies (J. Masserman ed. 1961-64).

"shock therapy" to more subtle forms of therapy such as ignoring certain symptoms and attitudes. Dr. Thomas S. Szasz observes the difficulties involved in presently defining what constitutes "illness," "treatment," and "patient" without confusing injection of an indefinable right to treatment.[17] As Dr. Szasz points out that it is extremely difficult to determine not only whether certain behavior constitutes "illness" but to determine what constitutes the best method of treatment or whether the chosen treatment is "adequate."

Dr. Szasz believes that what is termed a "right" to treatment should be labelled a "claim" for treatment and points out that a "right" to treatment for the patients would seriously impair a physician's prerogatives of choosing his patients and methods of treatment. This conflict is heightened in a state mental hospital where a physician cannot choose his patients.

The impossibilities of judicial definition and application of a right to treatment were discussed by now Chief Justice Burger in Lake v. Cameron, 124 U.S.App.D.C. 264, 364 F.2d 657, 663 (1966):

> ...this Court now orders the District Court to perform functions

---

17 Szasz, The Right to Health, 57 Geo. L.J. 734, 741, 743.

> normally reserved to social agencies by commanding search for a judicially approved course of treatment or custodial care for this mentally ill person who is plainly unable to care for herself. Neither this Court nor the District Court is equipped to carry out the broad geriatric inquiry proposed or to resolve the social and economic issued involved.

It has been strenuously argued in this and preceding cases that expert testimony is sufficient to guide a judge or jury to a proper determination as to what constitutes proper and adequate treatment in any specific case. The Court of Appeals accepted and applied that theroy in this case. While the testimony of experts and guidelines formulated by professional associations may be helpful in determining the adequacy of care provided by an entire hospital or system such as in an inquiry as in Wyatt v. Stickney, 325 F.Supp. 781, 784 (M.D.Ala. 1971), 344 F.Supp. 373, 375-376 (M.D.Ala. 1972), it cannot be easily applied to an individual patient. To attempt such application is to subject the professional judgment and decisions of a trained physician to the scrutiny of untrained laymen. It is common knowledge that any two physicians rarely treat any individual in the identical manner. One physician may consider some form of active treatment essential while another may choose to treat the symptoms by ignoring them.

A graphic illustration of a court faced with two widely divergent expert views on proper treatment, raised in the context of incompetence to stand trial, is provided in United States v. Klein, 325 F.2d 283, 286 (2nd Cir. 1963), wherein the Court lamented:

> Mental disorders being what they are, it is not surprising that eminent psychiatrists differ as to methods of treatment. Here Dr. Shoefield believed Klein would respond to a more psychoanalytic form of therapy; Dr. Douglas, by his own testimony, favored a more physiological approach. Courts of law, unschooled in the intricacies of what may be the most perplexing of medical sciences, are ill-equipped to choose among such divergent but responsible views. In a case like this, where a man's life may literally hang in the balance, a judge ought not undertake the hazardous venture of changing the course of psychiatric treatment without, at the least, a much fuller hearing and a greater preponderance of expert testimony than existed here.

Advocates of the right to treatment tend to ignore the difficulties of laymen sitting in judgment of the decisions of trained physicians with the argument that any judge who can allocate AM radio frequencies to avoid electronic interference is capable of

determining, with the aid of experts, which manner of treatment is "adequate" or "proper."[18] This Court recognized the dilemma in Greenwood v. United States, 350 U.S. 366 (1956), wherein Justice Frankfurter noted the transiency of psychiatry when reviewing the testimony of two psychiatrists, declaring:

> ...their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment...

This argument ignores the difference between the more exact science of electronics and the vague, fluid theories of psychotherapy. While it may be possible to determine whether one radio station will interfere with another with some degree of certainty, it has been demonstrated above that it cannot be said with equal certainty that one method of treatment is superior to another in any particular case.

Following the decision in Rouse v. Cameron, the American Psychiatric

---

[18] Bazelon, Implementing the Right to Treatment, 36 U.Chi.L.Rev. 742 (1969).

Association released a policy statement on the adequacy of treatment.[19]

The A.P.A. statement contends that "[t]he definition of treatment and the appraisal of its adequacy are matters for medical determination," but sets forth seven considerations relevant to a determination of whether a patient is receiving adequate care: (1) The purpose of hospitalization, and differences between long-term and short-term treatment programs; (2) the degree to which treatment is changed as diagnosis develops during institutionalization; (3) the need to protect the patient from self-inflicted harm; (4) the importance of interrupting the disease process, as in separating the psychotic from his family stress situation; (5) the effective use of physical therapies; (6) efforts to change the emotional climate around the patient meaning "mileau therapy" and related measures; and (7) the availability of conventional psychological therapies.[20] The statement strongly stresses the importance of considering the limitations of the staff and facilities at hand, and the absolute need for cooperation by the patient in his treatment program.[21]

---

[19] American Psychiatric Association, A Position Statement in the Question of Treatment, 123 Am. J. Psychiatry, 1458 (1967).

[20] Id. at 1458-1459.

[21] Id. at 1459-1460.

It has been suggested that it is no more difficult for a judge or jury to determine whether a patient has received "adequate" treatment than to hear a traditional medical malpractice case.[22] However, the analogy is not accurate. Physical medicine has a relative certainty compared with psychotherapy, both in diagnosis and in the efficacy of particular treatments. In the psychiatric malpractice field, the courts have exhibited extreme reluctance to examine issues of treatment and great confusion in trying to decide when negligence has occurred. Most of the cases involve such matters as discharge or failure to prevent escape from an institution, not the superiority of one form of treatment or therapy over another.[23] When a patient sues the doctor or hospital for negligent treatment, as in shock therapy injury cases, there is no comparison of treatments, but rather an examination of how the particular treatment was administered.[24]

---

22 Rouse v. Cameron, 373 F.2d at 457, n. 30.

23 J. Katz, J. Goldstein, & J. Dershowitz, Psychoanalysis, Psychiatry, and Law, 728-751 (1967).

24 CF. Hammer v. Rosen, 7 App.Div. 2d 216, 181 N.Y. S. 2d 805 (1959).

Negligence, a traditional guiding point for courts and juries in medical malpractice litigation, will be missing from federal cases seeking to enforce a constitutional right to treatment because negligence cannot form the basis of jurisdiction under the Civil Rights Acts. Smith v. Clapp, 436 F.2d 590 (3rd Cir. 1970); Isenberg v. Prasse, 433 F.2d 449 (3rd Cir. 1970).

The difficulties of one District Judge in attempting to define and apply a right to treatment are described in Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D.Ga. 1972), wherein Chief Judge Smith explored the requirements of civil rights jurisdiction, the nature of the asserted right to treatment, and the impossibilities of its definition and responsible application. Judge Smith concluded that there exists no affirmative federal constitutional right to treatment. Recent commentary recommends the approach taken in Burnham.[25] Professor Reisner notes that while objective standards might be judicially developed to be applied to institutions as a whole, he concludes that judicial attempts to gauge the appropriateness of treatment offered to individual patients cannot help but encounter the difficulties foreseen by the Burnham court.[26]

---

25 Reisner, Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends.

26 Id.

The Court of Appeals for the Fifth Circuit brushed aside objections that courts are incapable of determining what constitutes "adequate" treatment with the view that since other courts had attempted to do so, it must be that the judiciary is perfectly capable of sitting in judgment of the professional decisions of trained physicians. The Court also noted that there were cases, declaring the case at bar to be one, where the jury could determine whether a patient has been denied his "rights" by comparing the care he received under one physician to that he received under another. Both theories place laymen in the shoes of psychiatrists and the latter does not, as the Court of Appeals suggests, avoid the determination of which treatment or therapy is "adequate" or "proper" in any particular case.

The Court of Appeals argued further that a jury would be justified in finding a denial of "rights" by concluding that the defendants below obstructed the release of a patient even though they knew he was not receiving treatment. This theory ignores the fact that physicians in a state mental hospital are required to accept all patients committed to their care and are not empowered to release a patient until he is "cured." Even though a doctor may realize that a patient is not receiving treatment, or does not benefit from the available treatment, due to lack of available

staff, facilities, operating funds or other reasons, a doctor in a state institution simply lacks the statutory authority to release a mentally ill patient.

The Court of Appeals held that a quid pro quo, in the form of adequate treatment, must be advanced by the state in exchange for the liberty of the involuntarily committed mental patient. This theory ignores the realities providing the basic justification for involuntary confinement of the mentally ill. Involuntary commitment rests upon two interrelated foundations: (1) the "police power" of the state; and (2) the state's role as "parens patriae". The two are not easily separated in this setting. Basically, when the state provides mental health facilities for its citizens it acts in parens patriae. When the state involuntarily commits a citizen to a state mental health institution, it acts pursuant to its traditional police powers to protect the general public. A state has a strong interest in a healthy, productive, educated society.[27] Accordingly, for the benefit and protection of society, the state provides for state custody and maintenance of incompetent persons. The

---

[27] Penn Dairies v. Milk Control Commission, 318 U.S. 261 (1943).

[28] Prince v. Massachusetts, 321 U.S. 158 (1944).

[29] Jacobson v. Massachusetts, 197 U.S. 11 (1905).

state undertakes to care for those persons whose mental illness makes it difficult or impossible for them to care for themselves or to be cared for by their families, until such time as the patient is considered well enough to return to society. The state does that and nothing more.

The nature of treatment supplied beyond custodial care is a question for the states, not the federal courts. Whether a state shall provide a particular governmental service, and if so in what amount (qualitatively and quantitatively) are generally questions for the states and do not raise federal constitutional issues cognizable under 42 U.S.C. §1983, the Civil Rights Act of 1871, and 28 U.S.C. §1343(3).[30] It must be remembered that not every governmental function implies a corresponding right or "quid pro quo" as it has been termed by the Court of Appeals. Collins v. Hardyman, 341 U.S. 651 (1951); Niklaus v. Simmons, 196 F.Supp. 691 (D.Neb. 1961).

An analogous situation might be that of the public schools. School attendance is compulsory so it might be argued that there must, therefore, be a constitutional right to an adequate education as the

---

30 Fullington v. Shea, 320 F.Supp. 500 (D.Colo. 1970), affirmed 404 U.S. 963 (1970). CF. McGowan v. Maryland, 366 U.S. 420 (1961).

quid pro quo to those persons forced to attend school. Definition of such a right might be equally incapable of accurate definition. However, the quid pro quo theory has not been extended to the public schools. There is no right to an education even though attendance is involuntarily compelled.[31]

It was admitted by Respondent, in the pleadings, that there is no statutory right to treatment in Florida, as in the District of Columbia statute before the court in Rouse v. Cameron. Petitioner further believes, that there can be no federal constitutional right to treatment, as demonstrated above. Petitioner has shown that aside from the problem of determining what constitutes mental illness, that there is a bewildering array of accepted methods of therapy and a wide divergence of opinion between respected experts as to which method may be proper in a particular case. A right must be capable of definition. The proposed right of treatment defies definition; its application and enforcement are impossible in the absence of a definition.

This Court should grant certiorari to resolve the issue of whether there exists a constitutional right to treatment for persons involuntarily committed to a state mental hospital. This case presents the first opportunity for this Court to examine the issue presented, resolve

---

31 Fleming v. Adams, 377 F.2d 975, 977, (10th Cir. 1967), cert. den. 389 U.S. 898 (1967).

the issue of whether such a right exists, and, in so doing, provide necessary guidance for state administrators, patients, physicians and the lower federal courts.

II

CERTIORARI SHOULD BE GRANTED TO REVIEW THE HOLDING OF THE COURT OF APPEALS THAT, ASSUMING THE EXISTENCE OF A RIGHT TO ADEQUATE TREATMENT, ATTENDING PHYSICIANS AT A STATE MENTAL HOSPITAL MAY BE HELD PERSONALLY LIABLE, IN THE ABSENCE OF BAD-FAITH OR MALICE, FOR A DEPRIVATION OF THAT RIGHT.

The Court of Appeals for the Fifth Circuit held that the Petitioner and Dr. Gumanis, the other Appellant below, could properly be held personally liable for an alleged deprivation of the right to treatment.

Petitioner submits that a doctor in a state mental hospital should not be held personally liable for the deprivation of a constitutional right, whose existence and enforcement could not have been reasonably foreseen. Furthermore, doctors in a state hospital should not be held liable for deprivation of a constitutional right to adequate treatment, when they have no control over the number or nature of the patients they must treat, the facilities and resources available to them, or the statutory right to either refuse to treat a particular patient

or release a patient before he is restored to his mental health. The Court of Appeals found such considerations without merit.

It has been known for many years that state mental hospitals are woefully inadequate in terms of physical facilities, staff, and financing.[32] State mental hospitals are a creature and occasional victim of legislative fiat. They exist and operate on the funds made available by the legislature, and have only as many staff members as allowed by the annual appropriations bill. The administrator and staff have no meaningful control over the facilities and resources at their disposal. Likewise, they must accept every patient sent to them under a valid commitment order. They are not statutorily empowered to refuse any patient committed for care or discharge any patient who has not regained his mental health.

Against that set of facts, the Court of Appeals found that a doctor in a

---

32 Birnbaum, Some Remarks on the Right to Treatment, 23 Ala.L.Rev. 623 (1971); Birnbaum, A Rationale for the Right, 57 Geo. L.J. 752 (1969); Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960); Editorial, A New Right, 46 A.B.A.J. 516 (1960).

state institution using the limited resources available to him, could be held personally liable for failing to give adequate treatment, as determined by a court.

If the situation were not as serious as it is, it would be ludicrous to imagine a federal court finding that an over-worked, under-paid, staff psychiatrist in an over-crowded state hospital, working with a patient-staff ratio averaging five hundred patients per physician, using the meager facilities available to him, could be held personally liable in the amount of $23,000, to a former patient, for failing to foresee the existence of a previously unestablished constitutional right and failing to provide each and every patient with "adequate treatment", as determined by a group of laymen.

The controversy in this case centers around the effort to establish a right to treatment and demonstrate that Kenneth Donaldson was denied that right. The inequity arises when the right, if established, is applied retroactively to create monetary liability on the part of Petitioner and Dr. Gumanis. In essence, their wrongful acts, if any, consisted of the violation of a prospective right, assuming the present existence of a right to treatment. Justice Holmes once defined a prospective right as follows:

> A prospective right is not yet a right. It is only an expectation having certain intensity of

> reasonableness.[33]

The extreme difficulty of predicting the emergence of a new right or change in the law has been judicially recognized with increasing frequency in the past few years. Certainly, state officers and employees are not entitled to the absolute immunity accorded the judiciary, because that would frustrate the intent of Title 42 U.S.C. §1983. However, this Court has found that there is limited immunity for acts done in good faith by state officers, within the scope of their official duties.[34]

State employees and administrators should be required to act as reasonable and responsible men, but "they neither can nor should be expected to be seers in the crystal ball of constitutional doctrine. They are not charged with predicting the future course of constitutional law."[35] The Court of Appeals

---

[33] Southern Pacific R. R. Co. v. United States, 189 U.S. 447, 450 (1903).

[34] Pierson v. Ray, 386 U.S. 547, 555-557 (1967).

[35] Westberry v. Fisher, 309 F.Supp. 12 (D.Me. 1970); See also: Eslinger v. Thomas 476 F.2d 225 (4th Cir. 1973); Taylor v. Perini, 365 F.Supp. 557 (N.D.Ohio 1972); Skinner v. Spellman, 480 F.2d 539 (4th Cir. 1973); Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973); McKinney v. DeBord, 324 F.Supp. 928 (E.D.Cal. 1970).

for the Fifth Circuit noted that it was in conflict with the Ninth Circuit in Hoffman v. Halden, 268 F.2d 280 (9th Cir. 1959), but felt that the Hoffman rule was in error. The Court of Appeals believed that in the absence of such immunity, the District Judge's instruction to the jury on the good faith defense alone was sufficient.

Petitioner submits that he should be immune from damages in a situation where he was acting in good faith, according to accepted institutional policy and procedures, and could not reasonably be expected to foresee the future emergence and enforcement of a constitutional right to treatment. State employees should not be exposed to personal monetary liability for acts subsequently condemned as unconstitutional by the recognition of a new constitutional right.[36]

This Court should grant certiorari to determine whether it is proper for state-employed physicians at state mental hospitals to be held personally liable for deprivation of the proposed right to treatment even though such doctors have no control over the number of patients they must treat or the quality and quantity of treatment facilities available to them. So too, the Court should grant certiorari to resolve the apparent conflict between the Court of Appeals for the Fifth Circuit

---

36 Pierson v. Ray, supra, note 34.

and other Courts of Appeal on the issue of whether state employees and officers may be held personally liable for past actions, made in good faith, subsequently declared unconstitutional by the recognition of a new constitutional right.

III

CERTIORARI SHOULD BE GRANTED TO DETERMINE WHETHER, ASSUMING THERE IS A CONSTITUTIONAL RIGHT TO TREATMENT, THE RESPONDENT WAIVED THAT RIGHT.

In its opinion, the Court of Appeals for the Fifth Circuit noted that the Respondent, Donaldson, a Christian Scientist, refused to submit to either medication or shock therapy during his confinement at Florida State Hospital. The Court mentioned that recreational therapy, religious therapy and mileau therapy were substituted, but promptly dismissed all three forms of therapy as, in the opinion of the Court, inadequate. The Court emphasized their displeasure with "mileau therapy" citing a law review article, written by an attorney, as support for the notion that "mileau therapy" is an excuse used by psychiatrists to cover up a lack of adequate treatment.[37]

---

37 Halpern, A Practicing Lawyer Views the Right to Treatment, 57 Geo.L.J. 782, 786-787, n. 19 (1969).

Articles by physicians and psychiatrists take the opposite view that "mileau therapy" is often an excellent alternative or companion to medical or shock therapy.[38]

Assuming arguendo that there exists a constitutional right to treatment, is there a corresponding right to refuse treatment? Commentators suggest that a right to refuse treatment may be a necessary adjunct to the proposed right to treatment.[39] Statutes in Alaska and California expressly recognize a right to refuse on religious and other grounds.[40]

A natural question arises as to whether persons committed for reasons related to mental competency should be considered competent to consent to, or refuse offered treatment. California and Alaska statutes grant the

---

38 Cameron, Nonmedical Judgment of Medical Matters, 57 Geo.L.J. 716 (1969); J. Frank, Persuasion and Healing--A Comparative Study of Psychotherapy (1961).

39 Miller, Dawson, Dix and Parnas, Cases and Materials on Criminal Justice Administration and Related Processes - The Mental Health Process, 1663 (1971).

40 §7104, California Wel. & Inst. Code, (1969 Supp.); §47.30.130, Alaska Statutes, (1969 Supp.).

patient the right to decide so long as the administrators determine that he is in such a "condition of mind as to render him competent to make the decision."[41] Law review proponents of a right to treatment generally refuse, in their zealous protection of the patient's right to treatment, to recognize the right of a patient to refuse treatment.[42] Some suggest that a right to treatment imposes a duty to be treated.[43] Justice Holmes supported that view stating:

> While there are in some cases legal duties without a corresponding right; we never see a legal right without either a corresponding duty or compulsion stronger than duty.[44]

Whether there is a right to refuse treatment or a duty to be treated, the evidence in this case demonstrates

---

41 §7104 California Wel. & Inst. Code.

42 Halpen, A Practicing Lawyer Views the Right to Treatment, 57 Geo.L.J. 782, 801 (1969); Note, The Nascent Right to Treatment, 53 Va.L.Rev. 1134, 1140 (1967).

43 Katz, The Right to Treatment--An Enchanting Legal Fiction?, 36 U. of Chi. L.R. 755 (1969).

44 Holmes, Uncollected Letters, 66. See also: Ogden v. Saunders, 12 Wheat. 213, 281-82 (1827).

conclusively that either Donaldson exercised his right not to be treated or he utterly failed in his duty to be treated. The record is replete with evidence that he not only continually refused medicine and shock therapy, but that he refused, at times, to participate in occupational and group therapies. The Court in Rouse v. Cameron suggested that patient refusal to cooperate in therapy does not excuse lack of adequate treatment, but rather is a further indictment of the treatment facilities and staff. This attitude was prompted primarily by the requirements of the District of Columbia statute involved. However, the Court in Wyatt v. Stickney suggested that the same attitude should apply to the constitutional right to treatment. The Wyatt standard ignores the patient who refuses treatment or is unamenable to treatment.[45]

While the courts and commentators do not believe patient cooperation is a key element of adequate treatment, the American Psychiatric Association believes patient cooperation is a necessity.[46]

---

45 325 F.Supp. 781, 784 (M.D.Ala. 1971).

46 American Psychiatric Association, Position Statement on the Question of Adequacy of Treatment, 123 Am.J.Psychiatry 1458 (1967).

Donaldson, having continued to refuse numerous types of treatment, including shock treatment which had apparently been a successful element of his New York treatment, should not have been heard to complain of the "inadequacy" of his treatment. Therefore, even assuming the existence of a right to treatment, Donaldson could not present a valid claim. His actions should have been construed as an effective waiver or repudiation of any right to treatment. He failed to uphold his corresponding duty to be treated.

Certiorari should be granted to resolve the issue of whether, assuming the existence of a constitutional right to treatment, the Respondent, Donaldson, by his actions, effectively waived his right to treatment.

Conclusion

For the aforesaid reasons, it is respectfully prayed that a writ of certiorari be granted to review the judgment of the United States Court of Appeals for the Fifth Circuit.

Respectfully submitted,

ROBERT L. SHEVIN
Attorney General

DANIEL S. DEARING
Chief Trial Counsel

RAYMOND W. GEAREY
Assistant Attorney General

Dept. of Legal Affairs
The Capitol
Tallahassee, Florida

Counsel for Petitioner.

July 25, 1974.

A P P E N D I X

Kenneth DONALDSON, Plaintiff-Appellee,

v.

J. B. O'CONNOR, M. D. and John Gumanis, M. D.,
Defendants-Appellants.

No. 73 1813.

RECEIVED
JUN 26 1974
ATTORNEY GENERAL'S
OFFICE

United States Court of Appeals,
Fifth Circuit.

April 26, 1974.

Former patient who had been involuntarily committed, under civil commitment procedures, to state mental hospital brought action against attending physicians and others for deprivation of alleged constitutional right to receive treatment or be released from the hospital. The United States District Court for the Northern District of Florida, David L. Middlebrooks, Jr., J., rendered judgment against the attending physicians and they appealed. The Court of Appeals, Wisdom, Circuit Judge, held that patient had constitutional right to such treatment as would help him to be cured or to improve his mental condition; that evidence supported finding that attending physicians had acted in bad faith with respect to their treatment of patient and were personally liable for his injuries or deprivations of his constitutional rights; and that limitation period did not begin to run until patient's release from the hospital.

Affirmed.

1. Appeal and Error ⇨233(2)

Defendants' objections to instructions given at plaintiff's request were properly before the court on review of judgment in favor of plaintiff even though defendants did not object to

Synopses, Syllabi and Key Number Classification
COPYRIGHT © 1974, by WEST PUBLISHING CO.
The Synopses, Syllabi and Key Number Classification constitute no part of the opinion of the court

INDEXED

BEST COPY AVAILABLE

the instructions when they were discussed in chambers or after charge was read to jury where defendants did object to the instructions in a pretrial brief.

2. Constitutional Law ⇐255(5)

Where nondangerous patient is involuntarily committed under civil commitment procedures to state mental hospital, only constitutionally permissible purpose of confinement is to provide treatment and patient has due process right to such treatment as will help him to be cured or to improve his mental condition. U.S.C.A.Const. Amend. 14; 42 U.S.C.A. § 1983.

3. Constitutional Law ⇐255(1)

Generally, as matter of due process, long-term detention is permitted only when an individual is proved, in a proceeding subject to limitations of due process clause, to have committed a specific act defined as an offense against the state and such detention is allowed only for period of time explicitly fixed by sentence. U.S.C.A.Const. Amend. 14.

4. Constitutional Law ⇐255(1)

Where detention of individual is not in retribution for a specific offense, is not limited to fixed term and has not been preceded by proceeding in which fundamental procedural safeguards have been observed, there must be a quid pro quo, such as rehabilitative treatment or minimally adequate habilitation and care where rehabilitation is impossible, in order to justify confinement. U.S.C.A.Const. Amend. 14.

5. Civil Rights ⇐13.13(3)

In action by former mental patient who had been involuntarily committed under civil procedures to state mental hospital against attending physicians for deprivation of right to receive treatment or be released, evidence concerning withholding of treatment, blocking of efforts to have patient released, confinement of patient even though he was not dangerous or with reckless disregard as to whether he was dangerous and failure to do best that could have been done with available resources sustained determination that attending physicians had acted in bad faith and were personally liable for injuries sustained by patient and for deprivation of patient's right to receive treatment. U.S.C.A.Const. Amend. 14; 42 U.S.C.A. § 1983.

6. Federal Civil Procedure ⇐2096

Objection to composition of jury was not timely raised where it was not mentioned until after jury was impanelled. 28 U.S.C.A. § 1863(b)(5).

7. Federal Civil Procedure ⇐2092

Jury selection plan allowing certain specified classes of persons, including actively engaged members of the clergy and actively practicing attorneys, physicians, dentists and nurses to be excused from jury duty if they desired was in compliance with Jury Selection and Service Act. 28 U.S.C.A. § 1863(b)(5); U.S.C.A.Const. Amend. 7.

8. Limitation of Actions ⇐58(1)

Limitation period applicable to civil rights action brought by former patient of state mental hospital against attending physician for deprivation of his right to receive treatment or be released did not begin to run until patient's release from hospital; period did not begin to run on date patient was taken from care of defendant physician. 42 U.S.C.A. § 1983; F.S.A. § 95.11(4), (5)(a), (6).

9. Limitation of Actions ⇐55(6)

When tort involves continuing injury, cause of action accrues and limitation period begins to run at time tortious conduct ceases.

10. Limitation of Actions ⇐55(6)

Cause of action for false imprisonment does not accrue until release of imprisoned party.

11. Courts ⇐375(4)

In a civil rights suit, even though state statute of limitation is applicable, question of when cause of action has accrued is a matter of federal rather than state law. 42 U.S.C.A. § 1983.

12. Civil Rights ⇐13.4(1)

Attending physician was not entitled to immunity from liability under Civil Rights Act for deprivation of right of patient at state mental hospital to receive treatment absent finding that he had acted in good faith. 42 U.S.C.A. § 1983.

13. Civil Rights ⇐13.8(1)

Full range of officials' immunities available at common law does not apply in actions brought under Civil Rights Act. 42 U.S.C.A. § 1983.

14. Civil Rights ⇐13.13(3)

Evidence that physicians who attended patient who had been involuntarily committed to state mental hospital had acted maliciously, wantonly or oppressively was sufficient to sustain award of punitive damages for deprivation of patient's right to receive treatment or be released. 42 U.S.C.A. § 1983.

15. Civil Rights ⇐13.10

Failure of patient who had been involuntarily committed to state mental hospital to petition for restoration of his competency did not preclude determination that attending physicians had deprived patient of his right to receive treatment or to be released where state law did not permit person adjudged incompetent to petition on his own for restoration of competency. F.S.A. § 394.22.

Appeals from the United States District Court for the Northern District of Florida.

Before RIVES, WISDOM and MORGAN, Circuit Judges.

WISDOM, Circuit Judge:

This case requires us to decide for the first time the far-reaching question whether the Fourteenth Amendment guarantees a right to treatment to persons involuntarily civilly committed to state mental hospitals. The plaintiff-appellee, Kenneth Donaldson, was civilly committed to the Florida State Hospital at Chattahoochee in January 1957, diagnosed as a "paranoid schizophrenic". He remained in that hospital

BEST COPY AVAILABLE

for the next fourteen and a half years. During that time he received little or no psychiatric care or treatment.

Donaldson contends that he had a constitutional right to receive treatment or to be released from the state hospital. In this action, filed February 24, 1971, he seeks damages under 42 U.S.C. § 1983 [1] against five hospital and state mental health officials who allegedly deprived him of this constitutional right.[2] A jury returned a verdict of $28,500 in compensatory damages, and $10,000 in punitive damages against the two defendants-appellants, Dr. J. B. O'Connor and Dr. John Gumanis. Dr. O'Connor, as Acting Clinical Director of the Hospital, was Donaldson's attending physician from the time of his admission until mid-1959. He was Clinical Director of the Hospital from mid-1959 until late 1963, and Superintendent thereafter until his retirement February 1, 1971. Dr. John Gumanis was Donaldson's attending physician from the fall of 1959 until the spring of 1967. He was added as a defendant by an amended complaint filed April 20, 1972. The jury returned a verdict in favor of the other three defendants.

Gumanis and O'Connor bring separate appeals to this Court. They challenge the sufficiency of the evidence to support the

1. 42 U.S.C. § 1983 provides:
   Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

2. Except when the text clearly indicates otherwise, we use the term "defendants" in this opinion to refer to Dr. Gumanis and Dr. O'Connor, against whom judgments were rendered. The other three who were sued were: Dr. Francis G. Walls, who became Acting Superintendent of the Hospital when O'Connor retired from that position in February 1971, and who held that position for about four months; Dr. Milton J. Hirschberg, who became permanent Superintendent, succeeding O'Connor, in June 1971; and Emmett S. Roberts, Secretary of the Department of Health and Rehabilitative Services in Florida at the time Donaldson filed his First Amended Complaint August 30, 1971.

jury verdict [3] and they contend that the Constitution does not guarantee a right to treatment to mental patients involuntarily civilly committed. Both argue, therefore, that the trial judge erred in denying a motion to dismiss for failure to state a claim and in instructing the jury that civilly committed mental patients have a constitutional right to treatment. In addition, Gumanis raises a number of lesser issues. We hold that the Fourteenth Amendment guarantees involuntarily civilly committed mental patients a right to treatment, and that the evidence was sufficient to support the verdict. We also reject the numerous lesser contentions advanced by Gumanis. Accordingly, we affirm the judgment in Donaldson's favor.

I.

To put the legal issues in proper context as well as to discuss the defendants' challenge to the sufficiency of the evidence, it is essential to review the facts in unusual detail.

Donaldson was committed January 3, 1957, on the petition of his father and after a brief hearing before a county judge of Pinellas County, Florida. He was admitted to the Florida State Hospital twelve days later, and soon thereafter was diagnosed as a "paranoid schizophrenic". The committing judge told Donaldson that he was being sent to the hospital for "a few weeks" to "take some of this new medication", after which the judge said that he was certain that Donaldson would be "all right" and would "come back here". Donaldson was not released until July 31, 1971, after he had instituted this suit.

3. The defendants raised the question of the sufficiency of the evidence on a motion for directed verdict made at the close of the plaintiff's evidence, and renewed at the close of all evidence. The defendants apparently did not move for judgment notwithstanding the verdict after the verdict was returned, but they did move for a new trial. The first ground they asserted in their motion for new trial was that "[t]he verdict is contrary to the clear weight of the evidence, which evidence showed that Defendants reasonably believed in good faith that due to his mental illness and need of treatment Plaintiff was properly confined".

There is little dispute about the general nature of the conditions under which Donaldson was confined for almost fifteen years. Donaldson received no commonly accepted psychiatric treatment. Shortly after his first mental examination, Donaldson, a Christian Scientist, refused to take any medication or to submit to electroshock treatments, and he consistently refused to submit to either of these forms of therapy. No other therapy was offered. At trial, Gumanis mentioned "recreational" and "religious" therapy as forms of therapy given Donaldson; but this amounted to allowing Donaldson to attend church and to engage in recreational activities, privileges he probably would have been allowed in a prison. In the oral argument on appeal the appellants' counsel made much of what they called "milieu therapy", which they said was given Donaldson. This was nothing more than keeping Donaldson in a sheltered hospital "milieu" with other mental patients; the defendants did not refer to anything specific about the "milieu" that was in any special way therapeutic.[4] Donaldson was usually confined in a locked room, where, according to his testimony, there were about sixty beds, with little more room between beds than was necessary for a chair; his possessions were kept under the bed.

At night he was often wakened by some who had fits and by some "who would torment other patients, screaming and hollering". Then there was "the fear, always the fear you have in your heart, I suppose, when you go to sleep that maybe somebody would jump on you during the night". A

4. "Milieu therapy" is a frequent response by doctors and hospitals to claims by patients that they are receiving inadequate treatment. See Halpern, A Practicing Lawyer Views the Right to Treatment, 1969, 57 Geo.L.J. 782, 786-87, n. 19. Halpern discusses "milieu therapy" in discussing Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451, in which the District of Columbia Court of Appeals held that there was a statutory right to treatment. He notes that "milieu therapy" is an "amorphous and intangible" concept, "the easiest therapeutic claim for an institution to assert and the most difficult for a patient to refute", Halpern, *supra*, at 787 n. 19.

third of the patients in the ward were criminals. Indeed, Donaldson testified, "The entire operation of the ward was geared to criminal patients.[5]"

5. Some of Donaldson's testimony relating the conditions under which he lived is worth quoting:

"Q. Now, in the buildings you lived in Department A, were those buildings locked?
A. Yes, sir.
Q. Were the wards you lived on locked?
A. Yes.
Q. Were there metal enclosures on the windows?
A. Yes, padlocks on each window.
Q. Approximately how many beds were there in the rooms where you slept?
A. Sixty some beds.
Q. How close together were they?
A. Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.
Q. Did you have chairs in the room you were in?
A. There wasn't a chair in the room I was in.
Q. All right, was there an outside exercise yard for your department?
A. Yes, there was one period in particular when nobody went out for two years.
Q. Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?
A. That is right.
Q. Were there criminal patients on your ward?
A. There were criminal patients on the ward.
Q. Approximately what percent of the population on your ward were criminals?
A. Looking back, roughly, I would say a third. I do not know the figures for the whole department.
Q. Let's just talk about your ward.
A. Okay, I would say about a third in the wards I was in.
Q. Now, did you sleep in the same rooms as the criminal patients?
A. Yes.
Q. Did you get up at the same time?
A. Yes.
Q. Did you eat the same food?
A. Yes.
Q. In the same dining room?
A. Yes.
Q. Did you wear the same clothes?
A. Yes. The entire operation of the wards I was on was geared to the criminal patients.

During his first ten years at the hospital, progress reports on his condition were irregularly entered at intervals averaging about one every two and a half months. During those first ten years, he requested grounds privileges and occupational therapy; his requests were denied. In short, he received only the kind of subsistence level custodial care he would have received in a prison, and perhaps less psychiatric treatment than a criminally committed inmate would have received.

At the time Donaldson was admitted to the hospital in 1957, O'Connor was Assistant Clinical Director of the hospital. As Assistant Clinical Director, he was in charge of the hospital's Department A, then the white male ward, where Donaldson was assigned upon his admission to the hospital. In that

Q. Let me ask you, were you treated any differently from the criminal patients?
A. I was treated worse than the criminal patients.
Q. In what sense were you treated worse?
A. The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.
Q. For the criminal?
A. On the criminal patients, and that would be a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.
Q. Was there a place on the ward you had access to for keeping personal possessions?
A. No, not at that time.
Q. What did you do with your personal possessions?
A. I kept mine in a cedar box under the mattress of my bed.
Q. Was there a place in the wards where you could get some privacy?
A. No, not anytime in all of the years I was locked up.
Q. Were you able to get a good nights sleep?
A. No.
Q. Why not?
A. On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night.
They never did, but you think about those things. It was a lunatic asylum.

position, O'Connor was Donaldson's attending physician. At that time, Gumanis was a staff physician in Department A. On July 1, 1959, O'Connor became Clinical Director of the hospital, and in the fall of 1959, Gumanis was placed in charge of Department A, and became Donaldson's attending physician. O'Connor was promoted from the position of Clinical Director to the position of Superintendent July 30, 1963, and served as Superintendent until he retired February 1, 1971. Gumanis served as Donaldson's attending physician until April 18, 1967, when Donaldson was transferred to Department C, until that time the Negro male ward. After the transfer, Donaldson's attending physician was Dr. Israel Hanenson, the head of Department C until Dr. Hanenson's death in the fall of 1970. After that, until his release, Donaldson's attending physician was Dr. Jesus Rodriguez.

Donaldson brought this suit while he was still a patient at the hospital. In his original complaint, Donaldson sought to bring this suit as a class action on behalf of all patients in the hospital's Department C. In addition to damages, to the plaintiff and to the class, the complaint sought habeas corpus relief directing the release of Donaldson and of the entire class, and sought broad declaratory and injunctive relief requiring the hospital to provide adequate psychiatric treatment.

After Donaldson's release, and after the district court dismissed the action as a class suit, Donaldson, on August 30, 1971, filed his First Amended Complaint. This complaint sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. The complaint asked the district court to convene a three-judge district court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30 however, the plaintiff in a memorandum brief abandoned the prayer that a three-judge

BEST COPY AVAILABLE

court be convened. The prayers for injunctive and declaratory relief therefore were effectively eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights". The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionally limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization". Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on this verdict, Gumanis and O'Connor appeal.

The trial centered, of course, upon the conditions of Donaldson's confinement and upon the defendants' behavior toward Donaldson. On the record as a whole, there was ample

evidence to support the jury's reaching any or all of the conclusions set forth in the following subsections in Part I of this opinion.

A. *The defendants unjustifiably withheld from Donaldson specific forms of treatment.*

The evidence establishes that there were at least three forms of treatment the defendants withheld from Donaldson.

First, he was denied grounds privileges. Since the purpose of hospitalization is to restore the capacity for independent community living, one of the most basic modes of treatment is giving a patient an increasing degree of independence and personal responsibility. One of the plaintiff's expert witnesses was Dr. Walter Fox, Director of the Arizona Mental Health Department and former president of the Association of Medical Superintendents of Mental Hospitals. He had interviewed Donaldson and examined his hospital record. Fox testified that confining Donaldson to a locked building with no opportunity for grounds privileges was not "consistent" with a treatment plan for a patient with Donaldson's history.

Gumanis denied Donaldson a privilege card, even after Donaldson had asked him for one. Fox testified that it would have been "standard psychiatric practice" to extend grounds privileges to a patient of Donaldson's background, condition, and history. Gumanis, in his testimony at trial, could not give a convincing explanation for his refusal of grounds privileges to Donaldson.[6] At one point he sought to shift the responsibility for the refusal to O'Connor's shoulders, saying that he recalled having denied privileges after consultation with O'Connor. Later, he testified that at the time in question Donaldson had appeared to him to be "really upset", and that

6. Donaldson testified that he had once escaped from the hospital. This occurred around Christmastime 1957, shortly before the end of the first year Donaldson had spent at Florida State. The hospital records, however, did not show that a fear Donaldson would attempt to escape again motivated the denial of grounds privileges; nor have Gumanis and O'Connor asserted before this Court that such a fear was their reason for denying Donaldson a card.

he had "probably" made the decision to deny Donaldson a privilege card on his own.

Donaldson testified that soon after his transfer to Department C, Dr. Hanenson, the physician in charge of that department, gave him a privilege card.

The second form of treatment denied Donaldson was occupational therapy. Donaldson testified that Gumanis consistently refused to allow him to enter occupational therapy. This testimony was borne out by a progress note entered in Donaldson's hospital record January 17, 1964. Again, Fox testified that given what he called Donaldson's "social history", Donaldson would have been ideally suited to benefit from occupational therapy. According to Donaldson, Gumanis did not want him to go into occupational therapy, because Gumanis feared that he would learn touch-typing and would use this skill, in Donaldson's words, to "write writs", that is, to prepare habeas corpus petitions. Gumanis gave no reason why he denied Donaldson occupational therapy, although in the course of his testimony he did allude to the fact that he had done so. Not until Donaldson was transferred to Dr. Hanenson's care was he allowed to enter occupational therapy.

Third, the simplest and most routine form of psychiatric treatment is to have a patient talk with a psychiatrist. Donaldson testified that in the eighteen months O'Connor was in direct charge of his case, he spoke with O'Connor "not more than six times", and that the total time he spent talking to O'Connor did not consume more than one hour. He testified that in the eight and one-half years he spent under Gumanis' care, he did not speak with Gumanis more than a total of two hours—an average of about fourteen minutes a year. He testified that neither Gumanis nor O'Connor ever heeded his requests to discuss his case. On one occasion Gumanis said that he "talked only to patients that he wanted to". Gumanis did not recall that conversation. Once again, there was evi-

dence to show that the situation improved when Donaldson was transferred to Dr. Hanenson's care. Donaldson testified that Hanenson managed to speak with him once a week, even though, according to Donaldson, patients were more numerous, psychiatrists fewer, and conditions worse in Hanenson's Department C than they had been in Gumanis' Department A.

B. *The defendants recklessly failed to attend to and treat Donaldson at precisely those junctures when treatment could have most helped Donaldson recover and therefore be released.*

The jury could have concluded that Donaldson should have been marked, at his entrance to the hospital, as a prime candidate for an early release, and that the defendants acted recklessly in failing to treat or attend to him during the early stage of his confinement. Fox testified that, given Donaldson's history,[7] he should have been "pegged" for an "early discharge". Moreover, a progress note entered by Gumanis after his first diagnostic interview with Donaldson, March 25, 1957, recorded that Donaldson "appeared" to be "in remission". Gumanis defined "remission" for the jury as a state "when the patient does not express delusions or paranoid ideas", and told the jury that it was hospital practice to release patients who were in remission. He testified that Donaldson was not released because he wanted to "observe [Donaldson] further". But after that interview the first progress note entered in Donaldson's hospital record is dated four months later; and the next report five months after that. Asked about this, Gumanis first replied, "When you have 900 patients you do that"; later, he insisted that he had seen Donaldson frequently, but had not recorded progress notes after each observation. The jury, however, could have discounted this testimony and concluded that Gumanis acted wantonly in giving a patient who had appeared to be "in remission" the same treatment he gave his 900 other patients.

7. Fourteen years before he was hospitalized in Florida, Donaldson had been hospitalized at the Marcy State Hospital in New York, with the same diagnosis as that made by the Florida doctors—"paranoid schizophrenic". On that occasion, Donaldson was released after three months.

BEST COPY AVAILABLE

C. *The defendants wantonly, maliciously, or oppressively blocked efforts by responsible and interested friends and organizations to have Donaldson released to their custody.*

At issue here are two efforts made to secure Donaldson's release, one by Helping Hands, Inc., a Minneapolis organization which runs halfway houses for mental patients and John H. Lembcke, a college friend of Donaldson.

1. *The Helping Hands' attempt to obtain Donaldson's release.*

Helping Hands made an inquiry to the hospital concerning the possibility of releasing Donaldson to its custody by a letter dated June 6, 1963:

> We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters.

Enclosed with the letter was a brochure describing Helping Hands and a letter from the Minneapolis Clinic of Psychiatry and Neurology, stating that "it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care" provided at Helping Hands. The author of this letter pointed out that the woman identified by the letterhead as the founder and director of Helping Hands had "rehabilitated well over a thousand over the years". The letter requested information concerning Donaldson's age, health, and "qualifications for work".

The hospital responded June 17, 1973, in a letter signed by O'Connor, then Clinical Director of the hospital. It gave

Donaldson's age, and answered inquiries concerning his health and qualifications for work with the bare statement that Donaldson was "mentally incompetent at the present time." The crisp concluding paragraph read:

> Should he [Donaldson] be released from this Hospital, he will require very strict supervision, which he would not tolerate. Such a release would be to the parents. We see no prospects of his release to any third party at any time in the near future.

The jury could have decided that Gumanis and O'Connor acted wantonly and maliciously in issuing this response, and that this conduct foreclosed an opportunity for Donaldson to win back at least a part of his freedom, and to gain access to a level of psychiatric treatment unavailable to him at the Florida Hospital. Each of the defendants sought to shift the responsibility for sending this curt reply to the other's shoulders. They discussed the question in terms of whether hospital rules, in general, fixed responsibility for deciding whether a patient could be furloughed by the attending physician, or the Superintendent or Clinical Director; they did not discuss it in terms of their recollections of the particular event. The jury would have been justified in finding the two jointly responsible for the incident.

2. *The Lembcke attempt to obtain Donaldson's release.*

John H. Lembcke, a certified public accountant, in Binghamton, New York, who is married and has three children, had been a classmate of Donaldson's at Syracuse University in the 1920's. On four occasions, Lembcke sought to have Donaldson released to his custody. The first was on July 3, 1964, when Lembcke informed the hospital that Donaldson was a friend of his, and inquired whether there were "any conditions under which he would be released so that I could bring him back to New York State". The same day the hospital received the letter, O'Connor pencilled a note to Gumanis that is

BEST COPY AVAILABLE

attached to the letter in Donaldson's hospital record. The note said:

> This man must not be well himself to want to get involved with someone like this patient, who even the recent visiting psychologist considered *dangerous*—Recommend turn it down.

Rich, the new Clinical Director, wrote Lembcke saying that Donaldson had "shown no particular changes mentally", and that if released he would "require complete supervision".

The second inquiry came by letter of November 27, 1964. Again O'Connor appended a note to Gumanis that is in the hospital records. This note gave three reasons for denying Lembcke's request to have Donaldson released to him: parental consent would be required; the patient "would not stay with party mentioned"; and "we don't know anything about party". Gumanis prepared a letter, dated November 27 and again signed by Dr. Rich, "advising" Lembcke that Donaldson would "require further hospitalization". The reply did not mention the three reasons for the denial set out in O'Connor's note, and did not request any further information from Lembcke, even though Lembcke in his November 23 letter had offered to provide any information the hospital should request.

The third attempt by Lembcke began with another letter to the hospital, dated December 21, 1965. According to Lembcke's testimony, the hospital responded by saying Donaldson could be released on two conditions: (1) that Lembcke would give Donaldson "adequate supervision" so that the release would not be detrimental to his mental health; and (2) that Lembcke would secure parental permission for Donaldson to go to New York with Lembcke. In May 1966, Lembcke went to Florida, and met with Gumanis and O'Connor. While in Florida he saw Donaldson and obtained from Donaldson's parents a letter dated May 14, 1966, giving their consent to Donaldson's being released to him. Nothing happened. In his

testimony Lembcke did not explain how or why he came to abandon this 1966 effort to secure his friend's release.

Lembcke's final and most important effort to secure Donaldson's release began in March 1968. On March 21, the General Staff, at a meeting attended by Gumanis and Hanenson but not by O'Connor, recommended Donaldson's release on a trial visit or out-of-state discharge. On March 24, Lembcke wrote the hospital renewing his offer to take Donaldson. On March 28, the hospital responded, imposing three conditions on Donaldson's release: (1) that Lembcke be willing to come for Donaldson; (2) that he be willing to supervise Donaldson; and (3) that he be willing to take Donaldson to a psychiatrist if Donaldson needed treatment. By letter of March 31, Lembcke acceded to these conditions. On April 4, the hospital replied with a letter imposing two additional conditions: (1) a detailed statement concerning the home supervision Donaldson would be given; and (2) written authorization for the release from Donaldson's parents. Lembcke wrote back giving the hospital the information about home supervision it requested. The hospital replied by again saying it would be necessary to obtain the written consent of Donaldson's parents.

On September 18, 1968, Lembcke wrote the hospital, enclosing a photocopy of the notarized written permission Donaldson's parents had signed May 14, 1966. The hospital responded in a letter dated September 24, signed by Dr. Rich. The letter informed Lembcke that Donaldson had been mentally ill for many years, that he "still express[ed] delusional thinking" and that "it would not be fair to you or to him to release him from the hospital at this time without adequate planning". The letter added, in its final paragraph, that it would be necessary for the hospital to have more recent authorization from Donaldson's nearest relative than the one Lembcke had proffered. At that point, Lembcke gave up; whenever he met the conditions imposed by the hospital officials, new

conditions were imposed. As he put it, "after requirements were met, requirements were increased".

One other facet of Lembcke's last attempt to secure Donaldson's release bears mention. As noted, O'Connor did not attend the Staff Conference which had recommended Donaldson's release March 21. O'Connor first learned of the hospital's recommendation in June, when Donaldson wrote to the Division Director of the hospital concerning the effort being made to release him. The division director forwarded the letter to O'Connor, who in turn forwarded it to Hanenson, asking for information concerning the proposed release. Hanenson responded with a memorandum dated June 17. Across the bottom of this memorandum, O'Connor pencilled in the remark, "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise the patient". It was not clear when O'Connor supposed this "decision" to have been made, and in his deposition O'Connor was unable to locate any record of it in the hospital record. Moreover, there were suggestions in the record that Dr. O'Connor's conduct, in this and other respects, was influenced by his knowledge of Donaldson's history of writing letters to the press and to outside officials. From all of this evidence, the jury would have been justified in concluding that the frustration of Lembcke's effort to secure Donaldson's release in 1968 was entirely or primarily the result of O'Connor's bad faith intervention or, at the least, that the intervention was in reckless disregard of Donaldson's rights.

D. *The defendants continued to confine Donaldson knowing he was not dangerous, or with reckless disregard for whether he was dangerous.*

Three of the plaintiff's expert witnesses—Fox, Raymond D. Flowler, Jr., Chairman of the Psychology Department at the University of Alabama and former President of both the Alabama and Southern Psychological Associations, and Julian Davis, Director of the Psychology Department at the Florida State Hospital—testified that they did not believe Donaldson

was dangerous. Fox's and Flowler's opinions were based upon readings of the hospital records, Donaldson's psychological reports, Donaldson's past history, and raw data from his psychological examination. Lembcke testified that in his half century of having known Donaldson, he had never known Donaldson to be "violent", "aggressive", or "belligerent"; that, on the contrary, he knew Donaldson to be a "gentle" man. Dr. Walls testified that he did not believe Donaldson was physically dangerous; Gumanis himself conceded that he did not think Donaldson dangerous while Donaldson was in the hospital, although he said he could not predict what Donaldson would be like outside the hospital. There was no evidence in the record of Donaldson's ever having been violent in any way.

On the basis of this testimony the jury would have been justified in finding that Donaldson was not dangerous, and in inferring that the defendants knew him to be so.

E. *The defendants did not do the best they could with available resources.*

As they did in the district court, the defendants on appeal pitch their defense in substantial part on their contention that they did the best they could with limited resources available to the state psychiatric hospital. Donaldson rebuts this contention, first, by pointing out the contrast between the treatment he received from the defendants and that he received from Hanenson. Hanenson allowed him grounds privileges and occupational therapy, spoke with him frequently, and within a year of taking charge of his case arranged a staff conference that recommended his release. Second, he relies on the testimony of Fox and the other experts to the effect that Gumanis and O'Connor failed to take steps that would have been open to them to take, even given the admittedly stark limitations on the resources available to them. We agree that these two considerations were a sufficient basis for the jury to reject the defendants' defense that they did the best they could with available resources.

We turn now to the novel and important question whether civilly committed mental patients have a constitutional right to treatment.

II.

[1] The theory of Donaldson's cause of action under section 1983 was set forth in three of the instructions given by the trial judge. The first, instruction number 34, was a variation of a standard form "boiler plate" instruction found in 2 Dewitt & Blackmer's Federal Jury Practice & Instructions, 1970, § 87.05 (2d ed.) This instruction stated that there were four basic elements Donaldson had to prove to make out a claim under § 1983: (1) that the defendants "confined plaintiff against his will, knowing that he was not mentally ill or dangerous, and knowing that if mentally ill he was not receiving treatment for his mental illness"; (2) that defendants "then and there acted under the color of state law"; (3) that defendants' "acts and conduct deprived the plaintiff of his federal constitutional right not to be denied his liberty without due process of law as that phrase is defined and explained in these instructions"; and (4) that the defendants' "acts and conduct were the proximate cause of injury and consequent damage to the plaintiff". The other two instructions, 37 and 38, were the relevant instructions "defin[ing] and explain[ing]" the "phrase", "federal constitutional right not to be denied or deprived of his liberty without due process of law", within the meaning of instruction 34. These instructions told the jury:

37. You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his mental condition.

38. The purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not dangerous to himself or others. Without such

treatment there is no justification, from a constitutional standpoint, for continued confinement.

The propriety of these two instructions is the heart of the question raised by both O'Connor and Gumanis in their appeals.[8]

[2] The question for decision, whether patients involuntarily civilly committed in state mental hospitals have a constitutional right to treatment, has never been addressed by any of the federal courts of appeals. Three district courts, however, have decided the question within the last three years, two of which held that there is a constitutional right to treatment.[9]

8. As a threshold matter, Donaldson suggests that the objections to these instructions are not properly before this Court. He notes that the defendants did not object to that instruction either when the proposed instructions were discussed in chambers, or after the charge was read to the jury. The defendants did, however, object to what were then the plaintiff's proposed instructions 37 and 38 in a pretrial brief filed before the Court. There they asked that those instructions be replaced with an instruction that "[y]ou are instructed that a person who is committed to a mental hospital has a right to be released through judicial process when through no fault of his own treatment is not afforded and he is not dangerous to society or to himself". The trial judge refused this request, and gave the two instructions as the plaintiffs had proposed them. It is settled that "a failure to object may be disregarded if a party's position has previously been made clear to the court and it is plain that a further objection would be unavailing". 9 C. Wright & A. Miller, Federal Practice & Procedure § 2553 at 639–40; see, *e. g.*, Mays v. Dealers Transit, 7 Cir. 1971, 441 F.2d 1344; Steinhauser v. Hertz Corp., 2 Cir. 1970, 421 F.2d 1169. We find that was the case here, and therefore we consider that the objections are properly before the Court.

9. Two cases hold that there is a right to treatment for civilly committed mentally ill patients. Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, *on submission of proposed standards by defendants*, 334 F.Supp. 1341, enforced, 1972, 344 F.Supp. 373, 387, appeal docketed sub nom., Wyatt v. Aderholt, No. 72-2634, 5 Cir. Aug. 1, 1972; Stachulak v. Coughlin, N.D.Ill., 1973, 364 F.Supp. 686. One has held civilly committed mentally ill patients enjoy no right to treatment. Burnham v. Department of Public Health, N.D.Ga.1972, 349 F.Supp. 1335, appeal docketed, No. 72-3110, 5 Cir., Oct. 4, 1972.

A fourth case has recently held that civilly committed mentally retarded patients have a right to treatment. Welsch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, — F.Supp. —.

The Court of Appeals for the District of Columbia Circuit, in a case decided eight years ago, took note in dictum of the existence and seriousness of the question, although in the same case the court held that the Hospitalization of the Mentally Ill Act of 1964[10] creates a *statutory* right to treatment on the part of mental patients in the District of Columbia.[11] The idea of a constitutional right to treatment has received an unusual amount of scholarly discussion and support,[12] and there is now an enormous range of precedent

10. D.C.Code Ann. § 21-501.

11. Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451. Chief Judge Bazelon wrote for the Court:

> Absence of treatment "might draw into question 'the constitutionality of [this] mandatory commitment section' as applied." (1) Lack of improvement raises a question of procedural due process where the commitment is under D.C.Code § 24-301 rather than under the civil commitment statute, for under § 24-301 commitment is summary, in contrast with civil commitment safeguards. It does not rest on any finding of present insanity and dangerousness but, on the contrary, on a jury's reasonable doubt that the defendant was sane when he committed the act charged. Commitment on this basis is permissible because of its humane therapeutic goals. (2) Had appellant been found criminally responsible, he could have been confined a year, at most, however dangerous he might have been. He has been confined four years and the end is not in sight. Since this difference rests only on need for treatment, a failure to supply treatment may raise a question of due process of law. It has also been suggested that a failure to supply treatment may violate the equal protection clause. (3) Indefinite commitment without treatment of one who has been found not criminally responsible may be so inhumane as to be "cruel and unusual punishment." [Footnotes and citations omitted]

Id. at 453.

12. The landmark article in the field is Birnbaum, The Right to Treatment, 1960, 46 A.B.A. Journal 499. Much of the commentary in the area was stimulated by the *Rouse* decision. *E. g.*, Symposium—The Right to Treatment, 1969, 57 Geo.L.J. 673 (11 articles, 218 pages); Bazelon, Implementing the Right to Treatment, 1969, 36 U.Chi.L.Rev. 742; Birnbaum, Some Remarks on "The Right to Treatment," 1971, 23 Ala.L.Rev. 623; Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 1969, 70 Mich.L.Rev. 1108; Katz, The Right to Treatment—An Enchanting Legal Fiction? 1969, U.Chi.L.Rev. 755; Drake, Enforcing the Right to Treatment: Wyatt v. Stickney, 1972, 10 Am.Crim.L.Rev. 587; Morris, "Criminality" and the Right to

relevant to, although not squarely in point with, the issue.[13] The idea has been current at least since 1960, since the publication in the May 1960 issue of the American Bar Association Journal of an article by Dr. Morton Birnbaum, a forensic medical doctor now generally credited with being the father of the idea of a right to treatment.[14] The A.B.A. Journal editorially endorsed the idea shortly after the publication of Dr. Birnbaum's article.[15]

We hold that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.

In reaching this result, we begin by noting the indisputable fact that civil commitment entails a "massive curtailment of liberty" in the constitutional sense. Humphrey v. Cady, 1972, 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed.2d 394. The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary. Indeed, civil commitment, because it is for an indefinite term, may in some ways involve a more serious abridgement of personal freedom than imprisonment for commission of a crime usually does. Civil commitment involves stigmatizing the affected individuals, and the stigma attached, though in theory less severe than the stigma attached to criminal conviction, may in reality be as severe, or more so.[16] Since civil commitment involves deprivations of

Treatment, 1969, U.Chi.L.Rev. 784; Note, The Nascent Right to Treatment, 1967, 53 Va.L.Rev. 1134; Note, Civil Restraint, Mental Illness, and the Right to Treatment, 1967, 77 Yale L.J. 87; 80 Harv.L.Rev. 898 (1967).

13. See cases cited at nn. 23–44 *infra*.

14. Birnbaum, The Right to Treatment, 1960, 46 A.B.A.J. 499.

15. Editorial, A New Right, 1960, 46 A.B.A.J. 516.

16. On the recognition that stigmatization constitutes a deprivation of liberty in the constitutional sense, see Board of Regents v. Roth, 1972, 408 U.S. 564, 573, 92 S.Ct. 2701, 33 L.Ed.2d 548, 558 559.

liberty of the kind with which the due process clause is frequently concerned, that clause has the major role in regulating government actions in this area.

Beyond this, the conclusion that the due process clause guarantees a right to treatment rests upon a two-part theory. The first part begins with the fundamental, and all but universally accepted, proposition that "any nontrivial governmental abridgement of [any] freedom [which is part of the 'liberty' the Fourteenth Amendment says shall not be denied without due process of law] must be justified in terms of some 'permissible governmental goal.'" Tribe, Foreword—Toward a Model of Roles in the Due Process of Life and Law, 86 Harv.L.Rev. 1, 17 (1973). Once this "fairly sweeping concept of substantive due process" is assumed, *id.* at 5 n. 26,[17] the next step is to ask precisely what government interests justify the massive abridgement of liberty civil commitment entails. Typically, three distinct grounds for civil commitment are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care", "custody", or "supervision". Jackson v. Indiana, 1972, 406 U.S. 715, 737, 92 S.Ct. 1845, 32 L.Ed.2d 435; see Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 1966, 79 Harv.L.Rev. 1288, 1289–97; Note, 1967, The Nascent Right to Treatment, 53 Va.L.Rev. 1134, 1138–39.[18] It is analytically useful to conceive of these grounds as falling into two categories; one a

17. *See also* Ely, The Wages of Crying Wolf: A Comment on Roe v. Wade, 1973, 82 Yale L.J. 920, 935 & n. 91; Roe v. Wade, 1973, 410 U.S. 113, 172–173, 93 S.Ct. 705, 35 L.Ed.2d 147 (Rehnquist, J., dissenting); Doe v. Bolton, 1973, 410 U.S. 179, 223, 93 S.Ct. 739, 35 L.Ed.2d 201 (White, J., dissenting).

18. In *Jackson*, the Supreme Court, relying upon an American Bar Foundation study, found that in nine states the sole criterion for involuntary commitment was the danger to self or others; that in 18 other states the patient's need for care or treatment was an alternative basis; that the need for care or treatment was the sole basis in six other states; and a few states had no statutory criteria at all and "presumably le[ft] the determination to judicial discretion". 406 U.S. at 737 n. 19, citing American Bar Foundation, The Mentally Disabled and the Law (rev. ed. 1971) at 36–49.

"police power" rationale for confinement, the other a "*parens patriae*" rationale.[19] Danger to others is a "police power" rationale; need for care or treatment a "*parens patriae*" rationale. Danger to self combines elements of both.

The key point of the first part of the theory of a due process right to treatment is that where, as in Donaldson's case, the rationale for confinement is the "*parens patriae*" rationale that the patient is in need of treatment, the due process clause requires that minimally adequate treatment be in fact provided. This in turn requires that, at least for the nondangerous patient, constitutionally minimum standards of treatment be established and enforced. As Judge Johnson expressed in the *Wyatt* case: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." Wyatt v. Stickney, *supra*, 325 F.Supp. at 785. Or as Justice Cutter, speaking for the Supreme Judicial Court of Massachusetts, put it: "Confinement of mentally ill persons, not found guilty of crime, without affording them reasonable treatment also raises serious questions of deprivation of liberty without due process of law. As we said in the *Page* case [citation omitted], of a statute permitting comparable confinement, 'to be sustained as a nonpenal statute . . . it is necessary that the remedial aspect of confinement . . . have foundation in fact.'" Nason v. Superintendent, Bridgewater Hospital, 1968, 353 Mass. 604, 612, 233 N.E.2d 908, 913. This key step in the theory also draws considerable support from, if indeed it is not compelled by, the Supreme Court's recent decision in Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435. In *Jackson*, the Supreme Court established the rule that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual is committed". 406 U.S. at 738.[20] If the "purpose" of commitment is treatment, and treatment is not provided, then the "nature" of the commitment bears no "reasonable relation" to its "purpose", and the constitutional rule of *Jackson* is violated.

19. See Note, The Nascent Right to Treatment, 1967, 53 Va.L.Rev. 1134, 1138-39.

[3, 4] This much represents the first part of the theory of a due process right to treatment; persons committed under what we have termed a *parens patriae* ground for commitment must be given treatment lest the involuntary commitment amount to an arbitrary exercise of government power proscribed by the due process clause. The second part of the theory draws no distinctions between persons committed under "*parens patriae*" rationales and those committed under "police power" rationales. This part begins with the recognition that, under our system of justice, long-term detention is, as a matter of due process, generally permitted only when an individual is (1) proved, in a proceeding subject to the rigorous constitutional limitations of the due process clause of the fourteenth amendment and the Bill of Rights, (2) to have committed a *specific act* defined as an offense against the state. See Powell v. Texas, 1968, 392 U.S. 514, 533, 542-543, 88 S.Ct. 2145, 20 L.Ed.2d 1254 (Black, J., concurring). Moreover, detention, under the criminal process, is usually allowed only for a period of time explicitly fixed by the prisoner's

20. *Jackson* involved a mentally defective deaf mute who was committed after the court determined that he was incompetent to stand trial. Since the mental and physical defects which were the cause of his inability were not susceptible to treatment and not likely to improve during his confinement, it was unlikely that he would ever become competent to stand trial. In the circumstances, the Supreme Court held that its rule that "the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed" permitted the state to confine Jackson under the provisions for the commitment of those found incompetent to stand trial only for "the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity [to stand trial] in the foreseeable future". It held further that even if it were determined that he was likely to become able to stand trial, "his continued commitment [would have to be] justified by progress toward that goal". 406 U.S. at 738.

sentence. The second part of the theory of a due process right to treatment is based on the principle that when the three central limitations on the government's power to detain - that detention be in retribution for a specific offense; that it be limited to a fixed term; and that it be permitted after a proceeding where fundamental procedural safeguards are observed--are absent, there must be a *quid pro quo* extended by the government to justify confinement.[21] And the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment, or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary.[22]

21. One theory is that commitment pursuant to civil statutes generally lacks the procedural safeguards afforded those charged with criminal offense. The constitutional justification for this abridgment of *procedural rights* is that the purpose of commitment is treatment. (Emphasis supplied).

Welsch v. Likins, No. 4-72 Civ. 451, D.Minn., Feb. 15, 1974, ---- F.Supp. -- at --. *See also* Inmates of Boys' Training School v. Affleck, D.R.I.1972, 346 F.Supp. 1354, 1368; Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451, 453 (Bazelon, C. J.); Note, Civil Restraint, Mental Illness and the Right to Treatment, 1967, 77 Yale L.J. 87, 90-91, 102-03 & nn. 62-63.

22. Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense."

Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, 784, quoting Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (Fahy, J., concurring). *See also* cases cited in nn. 23-24 *infra*.

Of the various formulations of this "*quid pro quo*" theory we have found, perhaps the most successful is that made by Professor Nicholas Kittrie, writing specifically about confinement of juveniles, but articulating a theory equally applicable to civil commitment of mentally ill persons:

> Our society has increasingly divested certain groups from the traditional criminal justice court and, acting under its asserted role of *parens patriae*, substituted new therapeutic controls.
>
> * * * * * * * * * *
>
> A new concept of substantive due process is evolving in [this] therapeutic realm. This concept is founded upon a recognition of the concurrency between the state's exercise of sanctioning powers and its assumption of the duties of social responsibility. Its implication is that effective treatment must be the *quid pro quo* for society's right to exercise its *parens patriae* controls. Whether specifically recognized by statutory enactment or implicitly derived from the constitutional requirements of due process, the right to treatment exists.

Kittrie, Can the Right to Treatment Remedy the Ills of the Juvenile Process? 1969, 57 Geo.L.J. 851-52, 870.

This second part of the theory draws a wide range of support from a variety of precedents. The relevant cases have arisen in five major procedural contexts.

The earliest group of relevant cases consists of cases decided on habeas corpus petitions brought by citizens held under provisions for various kinds of "nonpenal" confinement, who were being held in correctional facilities for prisoners convicted of crimes. These cases uniformly hold that, where detention is "nonpenal" in theory, the very least that is required is that the persons be confined in a facility other than a prison.[23]

Later cases expand the view of these cases by holding not only that persons held under provisions for "nonpenal" confinement be held elsewhere than in a prison, but that they must be held in places where the conditions are *actually* therapeutic.[24]

The third line of relevant cases are those where the constitutionality of various modern "nonpenal" statutes—notably sex-offender and defective-delinquent statutes—provide for the confinement of habitual criminal offenders to protect

23. Benton v. Reid, 1956, 98 U.S.App.D.C. 27, 231 F.2d 780; Commonwealth v. Page, 1958, 339 Mass. 313, 159 N.E.2d 82; In re Maddox, 1958, 351 Mich. 358, 88 N.W.2d 470; *cf.* Miller v. Overholser, 1953, 92 U.S.App.D.C. 110, 206 F.2d 415.

24. But this mandatory commitment provision rests upon a supposition, namely, the necessity for treatment of the mental condition which led to the acquittal by reason of insanity. And this necessity for treatment presupposes in turn that treatment will be accorded.

Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (Fahy, J., concurring), quoted with approval, Darnell v. Cameron, 1965, 121 U.S.App.D.C. 58, 348 F.2d 64, 67-68, (Bazelon, C. J.); Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, 517, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Commonwealth v. Page, 1959, 339 Mass. 313, 317, 159 N.E.2d 82, 85.

society and to provide rehabilitative care. The decisions have upheld such statutes, but the courts have usually added the proviso that the constitutionality of the statute is conditioned upon the *realization* of the statutory promise of rehabilitative treatment.[25]

The fourth set of cases, highlighted by Rouse v. Cameron[26] and Nason v. Superintendent of Bridgewater State Hospital,[27] consists of cases where individuals under confinement have brought habeas corpus petitions challenging their confinement on the ground that they were not receiving treatment. This is a diverse group of cases; in most of them, the challenge to confinement for lack of treatment has been combined with challenges brought on other grounds, and often the other grounds are the subject of the decisions. Among these cases,

25. For those in the category [of defective delinquents] it [the defective delinquents statute] would substitute psychiatric treatment for punishment in the conventional sense and would free them from confinement, not when they have "paid their debt to society," but when they have been sufficiently cured to make it reasonably safe to release them. With this humanitarian and progressive approach to the problem no person who has deplored the inadequacies of conventional penological practices can complain. But a statute though "fair on its face and impartial in appearance" may be fraught with the possibility of abuse in that if not administered in the spirit in which it is conceived it can become a mere device for warehousing the obnoxious and antisocial elements of society. . . . *Deficiencies in staff, facilities, and finances would undermine the efficacy of the Institution and the justification for the law, and ultimately the constitutionality of its application.* [Footnotes omitted]
Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, 517, cert. dismissed as improvidently granted sub nom. Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791 (emphasis supplied). *See also* Davy v. Sullivan, M.D.Ala.1973, 354 F.Supp. 1320, (sex offender statute) (three-judge court).

26. 1966, 125 U.S.App.D.C. 366, 373 F.2d 451 (Bazelon, C. J.). The District of Columbia Circuit has reaffirmed its *Rouse* holding on numerous occasions. See, *e. g.*, In re Curry, 1971, 147 U.S.App.D.C. 28, 452 F.2d 1360; Covington v. Harris, 1969, 136 U.S.App.D.C. 35, 419 F.2d 617; Tribby v. Cameron, 1967, 126 U.S.App.D.C. 327, 379 F.2d 104; Dobson v. Cameron, 127 U.S.App.D.C. 324, 383 F.2d 519; Millard v. Cameron, 1966, 125 U.S.App.D.C. 383, 373 F.2d 468.

27. 353 Mass. 604, 233 N.E.2d 908 (1968) (Cutter, J.).

however, we have found none where any court has declared that no right to treatment exists, and we have found none explicitly recognizing a *constitutional* right to treatment. When they hold that there is a right to treatment, the cases usually either rest on statutory grounds, or are ambiguous as to whether they are resting upon statutory or constitutional grounds.[28] But in all cases, the courts have at least sustained the right of a petitioner to a hearing to develop the facts supporting his claim that he is not receiving treatment.[29]

Fifth, and last, among the groups of cases is the spate of recent cases brought as class actions in federal court, seeking broad forms of injunctive and declaratory relief requiring that adequate treatment be provided in state-run facilities. The cases have included attacks on conditions in many types of facilities—including facilities for the mentally ill,[30] the mentally retarded,[31] juvenile delinquents[32] or nondelinquent juveniles held as being "persons in need of supervision".[33]

28. *But see* Stachulak v. Coughlin, N.D.Ill.1973, 364 F.Supp. 686, a case of this kind, citing *Wyatt* and holding there is a constitutional right to treatment.

29. *E. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (characterizing committed sex offender's claim that he was not receiving treatment a "substantial constitutional claim", and remanding for a hearing on, inter alia, that issue).

30. See cases cited in note 9 *supra*.

31. Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 387; Welsch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, —— F.Supp. ——. *Contra*, New York State Ass'n for Retarded Children, Inc. v. Rockefeller, E.D.N.Y.1973, 357 F.Supp. 752.

32. Nelson v. Heyne, 7 Cir. 1974, 491 F.2d 352, aff'g N.D.Ind.1972, 355 F.Supp. 451; Inmates of Boys' Training School v. Affleck, D.R.I.1972, 346 F.Supp. 1354; Morales v. Turman, E.D.Tex.1973, 364 F.Supp. 166.

33. Martarella v. Kelley, S.D.N.Y.1972, 349 F.Supp. 575, enforced, 359 F.Supp. 478.
The closest the Supreme Court has come to speaking directly on the second, more important part of the due process right to treatment theory we articulate, came in In re Gault, 1967, 387 U.S. 1, 22

Taken together, these five sets of cases constitute a near unanimous recognition that governments must afford a *quid pro quo* when they confine citizens in circumstances where the conventional limitations of the criminal process are inapplicable. These five groups include cases decided by all levels of courts—the Supreme Court,[34] the courts of appeals,[35] the federal district courts,[36] and the state courts.[37] One or another of them concerns each of the major forms of "nonpenal confinement: from those with a heavy police power emphasis, such as

n. 30, 87 S.Ct. 1428, 18 L.Ed.2d 527, in which the Court, discussing the context of juvenile confinement, wrote:

> While we are concerned only with procedure before the juvenile court in this case, it should be noted that to the extent that the special procedures for juveniles are thought to be justified by the special consideration and treatment afforded them, there is reason to doubt that juveniles always receive the benefits of such a *quid pro quo* . . . The high rate of juvenile recidivism casts some doubt upon the adequacy of treatment afforded juveniles . . .
>
> In fact some courts have recently indicated that appropriate treatment is essential to the validity of juvenile custody, and therefore that a juvenile may challenge the validity of his custody on the ground that he is not in fact receiving any special treatment.

34. Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435; Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; McNeil v. Director, Patuxent Institution, 1972, 407 U.S. 245, 92 S.Ct. 2083, 32 L.Ed.2d 719.

35. *E. g.*, Nelson v. Heyne, *supra* note 39; Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, *cert. dismissed as improvidently granted* sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 541.

36. *E. g.*, cases cited in nn. 9, 31–33, *supra*.

37. *E. g.*, Nason v. Superintendent, Bridgewater Hospital, 1968, 353 Mass. 604, 233 N.E.2d 908; Commonwealth v. Page, 1959, 339 Mass. 313, 159 N.E.2d 82; In re Maddox, 1958, 351 Mich. 358, 88 N.W.2d 470.

confinement of sex offenders[38] or defective delinquents,[39] of persons acquitted by reason of insanity,[40] or of persons held incompetent to stand trial;[41] those with a heavy *parens patriae* emphasis, such as confinement of the mentally retarded,[42] or of juveniles;[43] and those—such as civil commitment of the mentally ill[44]—with elements of both rationales behind them.

The appellants argue strenuously that a right to constitutionally adequate treatment should not be recognized, because such a right cannot be governed by judicially manageable or ascertainable standards. In making the argument, they rely heavily upon the Northern District of Georgia's decision in Burnham v. Department of Public Health, 1972, 349 F.Supp. 1335, 1341–1343. In *Burnham*, the district judge held that a class action seeking declaratory and injunctive relief requiring the Georgia Department of Public Health to provide treatment at Georgia mental hospitals presented a nonjusticiable controversy. He quoted Baker v. Carr, 1962, 369 U.S. 186,

38. *E. g.*, Humphrey v. Cady, 1972, 405 U.S 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; Davy v. Sullivan, M.D.Ala.1973, 354 F.Supp. 1320 (three-judge court); Commonwealth v. Page, 1959, 339 Mass. 313, 159 N.E.2d 82.

39. *E. g.*, Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791.

40. *E. g.*, Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451 (Bazelon, C. J.); Darnell v. Cameron, 1965, 121 U.S.App.D.C. 58, 348 F.2d 64 (Bazelon, C. J.); Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943 (Burger, J.).

41. Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435. *See also* Greenwood v. United States, 1956, 350 U.S. 366, 76 S.Ct. 410, 100 L.Ed. 412; United States v. Pardue, D.Conn.1973, 354 F.Supp. 1377; United States v. Jackson, N.D.Cal.1969, 306 F.Supp. 4.

42. *E. g.*, Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 387; Welsch v. Likins, No. 4-72 Civ. 451, D.Minn. Feb. 15, 1974, noted, 42 U.S.L.W. 1141–42.

43. Cases cited in notes 32–33.

44. Cases cited in note 9 *supra*.

198, 82 S.Ct. 691, 700, 7 L.Ed.2d 663, for the proposition that determining whether a suit was justiciable requires determining whether "the duty asserted can be judicially identified and its breach judicially determined, and whether protection for the right asserted can be judicially molded". 349 F.Supp. at 1341, quoting 369 U.S. at 198. He then cited the ambiguity of the dictionary definition of treatment, a passage from a law review article noting the fact that there are as many as forty different methods of psychotherapy,[45] and a passage from the Supreme Court's decision in Greenwood v. United States, 1956, 350 U.S. 366, 76 S.Ct. 410, 100 L.Ed. 412, concerning the "tentativeness" and "uncertainty" of "professional judgment" in the mental health field.[46] He concluded: "[T]he claimed duty (i. e. to 'adequately' or 'constitutionally treat') defies judicial identity and therefore prohibits its breach from being judicially defined." 349 F.Supp. at 1342.

The defendants' argument can be answered on two levels. First, we doubt whether, even if we were to concede that courts are incapable of formulating standards of adequate

45. Levine [M. Levine, Psychotherapy in Medical Practice] lists 40 methods of psychotherapy. Among these, he includes physical treatment, medicinal treatment, reassurance, authoritative firmness, hospitalization, ignoring of certain symptoms and attitudes, satisfaction of neurotic needs and bibliotherapy. In addition, there are physical methods of psychiatric therapy, such as the prescription of sedatives and tranquilizers, the induction of convulsions by drugs and electricity, and brain surgery. *Obviously, the term "psychiatric treatment" covers everything that may be done under medical auspices—and more.*

If mental treatment is all the things Levine and others tell us it is, how are we to determine whether or not patients in mental hospitals receive adequate amounts of it?

Szasz, The Right to Psychiatric Treatment: Rhetoric and Reality, 1969, 57 Geo.L.J. 740, 741.

46. . . . [T]heir [two court-appointed psychiatrists] testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment.

Greenwood v. United States, 1956, 350 U.S. 366, 375, 76 S.Ct. 410, 415, 100 L.Ed. 412.

treatment in the abstract, that we could or should for that reason alone hold that no right to treatment can be recognized or enforced. There will be cases—and the case at bar is one—where it will be possible to make determination whether a given individual has been denied his right to treatment without formulating in the abstract what constitutes "adequate" treatment. In this case, the jury properly could have concluded that Donaldson had been denied his rights simply by comparing the treatment he received while he was under Gumanis's and O'Connor's care with that he received while under Hanenson's care; or it could have concluded that Donaldson's rights had been violated on the basis of the evidence that the defendants obstructed his release even though they knew he was receiving no treatment. Neither judgment required any *a priori* determination of what constitutes or would have constituted adequate treatment, and of course no such determination was made.

We do not, however, concede that determining what constitutes adequate treatment is beyond the competence of the judiciary. In deciding in individual cases whether treatment is adequate, there are a number of devices open to the courts, as Judge Bazelon noted in discussing the implementation of the statutory right to treatment in the landmark case of Rouse v. Cameron:

> But lack of finality [of professional judgment] cannot relieve the court of its duty to render an informed decision. Counsel for the patient and the government can be helpful in presenting pertinent data concerning standards for mental care, and, particularly when the patient is indigent and cannot present experts of his own, the court may appoint independent experts. Assistance might be obtained from such sources as the American Psychiatric Association, which has published standards and is continually engaged in studying the problems of mental care. The court could also consider inviting the psychiatric and legal communities to

establish procedures by which expert assistance can be best provided. [Footnotes omitted].

373 F.2d at 457. There are by now many cases where courts have undertaken to determine whether treatment in an individual case is adequate or have ordered that determination to be made by a trial court.[47] Even in cases like *Wyatt* and *Burnham*, when courts are asked to undertake the more difficult task of fashioning institution-wide standards of adequacy, the task should not be beyond them. The experience of the *Wyatt* case bears this out. In *Wyatt*, agreement was reached among the parties on almost all of the minimum standards for adequate treatment ordered by the district court, and the defendants joined in submitting the standards to the district court. These stipulated standards were supported and supplemented by testimony from numerous expert witnesses. Moreover, there was a striking degree of consensus among the experts, including the experts presented by the defendants, as to the minimum standards for adequate treatment. The standards developed have not been challenged by the defendants in the appeal now pending before this Court. See Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 373, 375–376.

In summary, we hold that where a nondangerous patient is involuntarily civilly committed to a state mental hospital, the only constitutionally permissible purpose of confinement is to

47. See, e. g., Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; In re Curry, 1971, 147 U.S.App.D.C. 28, 452 F.2d 1360; United States v. Waters, 1970, 141 U.S.App.D.C. 289, 437 F.2d 722; Dobson v. Cameron, 1967, 127 U.S.App.D.C. 324, 383 F.2d 519; Tribby v. Cameron, 126 U.S.App.D.C. 327, 379 F.2d 104; Millard v. Cameron, 1966, 125 U.S.App.D.C. 383, 373 F.2d 468; Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, remanding, D.Md., 1969, 295 F.Supp. 389, aff'd sub nom., Tippett v. Maryland, 1971, 436 F.2d 1153, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Dixon v. Atty. Gen'l of Pennsylvania, M.D.Pa.1971, 325 F.Supp. 966 (three-judge); In re Jones, D.D.C.1972, 338 F.Supp. 428; Clatterbuck v. Harris, D.D.C.1968, 295 F.Supp. 84; Nason v. Supt. of Bridgewater State Hospital, 1968, 353 Mass. 604, 233 N.E.2d 908.

provide treatment, and that such a patient has a constitutional right to such treatment as will help him to be cured or to improve his mental condition. We hold that the district court did not err in so instructing the jury.

III.

[5] Gumanis and O'Connor join in contending that the evidence at trial did not permit the jury to find that they acted in bad faith, and that therefore they cannot be held personally liable for Donaldson's injuries or the deprivations of his constitutional rights. Gumanis's arguments concern primarily his role in deciding whether Donaldson could or should be released. He asserts that he acted throughout in good faith and in the reasonable belief that Donaldson was mentally ill and required further confinement. O'Connor's argument is directed not only toward his acts affecting the decision whether to release, but also to the entirety of his conduct while Donaldson was held at Florida State. O'Connor argues that both he and Gumanis did the best they could with available resources, and therefore should not be held personally liable for whatever was done to Donaldson. He cites in his brief the various limitations of staff and funds available to the state psychiatrists at Florida State, the difficulties hospital administrators have had in winning approval of their budgets from the state legislatures, and similar matters; and he argues, on that basis, that the denial of whatever right to treatment Donaldson had was the product of the actions of the legislature and of the realities of the budgetary situation, and not of the actions of the state psychiatrists to whose care Donaldson was entrusted.

We find the appellants' objection, in all of its various forms, without merit.

The trial judge instructed the jury:

> The defendants in this action rely on the defense that they acted in good faith. Simply put, defendants contend they in good faith believed it was necessary to detain

plaintiff in the Florida State Hospital for treatment for the length of time he was so confined. If the jury should believe from a preponderance of the evidence that defendants reasonably believed in good faith the detention of plaintiff was proper for the length of time he was confined then a verdict for defendants should be entered even though the jury may find the detention to have been unlawful.

However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify plaintiff's confinement in the Florida State Hospital. As a corollary plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual deprivation of constitutional rights or other rights guaranteed by law.

The defendants did not object to this instruction, and do not challenge its correctness here.[48] The instruction was proper, and that there was sufficient evidence to support a jury finding that the defendants did not act at all times in a good faith and reasonable belief that Donaldson needed continued confinement and that continued confinement was lawful. In effect, the jury found, on the facts, that Donaldson's right to treatment was denied not, or not only by the limitations of funds and staff and resources under which the hospital operated, but also by the actions of Gumanis and O'Connor themselves.

We are "duty bound to accept all evidence in favor of the verdict as true and to give such evidence the benefit of all permissible inferences that would help sustain the jury's decision". Little v. Green, 5 Cir. 1970, 428 F.2d 1061, cert. denied, 400 U.S. 964, 91 S.Ct. 366, 27 L.Ed.2d 384; Grey v. First National Bank, 5 Cir. 1968, 393 F.2d 371, 381. We hold therefore that the evidence supported the jury's finding that the defendants did not act in good faith.

48. Dowsey v. Wilkins, 5 Cir. 1972, 467 F.2d 1022, 1025-1026.

IV.

The first contention made by Gumanis alone is that the Northern District of Florida's jury selection plan operated to abridge his right to a jury trial under the seventh amendment and under 28 U.S.C. §§ 1861, 1862, by permitting the "systematic exclusion" of physicians from the jury rolls. Gumanis raised his objection to the composition of the jury on the first day of the trial, but after the jury had been impanelled and sworn. The Northern District selection plan allows certain specified classes of person, including "actively engaged members of the clergy" and "actively practicing attorneys, physicians, and dentists, and registered nurses", to be excused from jury duty if they so desire. The authority for these exceptions is an express provision of the Jury Selection and Service Act. 28 U.S.C. § 1863(b)(5) provides that a jury selection plan shall "specify those groups of persons or occupational classes whose member shall, on individual request therefore be excused from jury service. . . . if the district court finds, and the plan states, that jury service by such class or group would entail undue hardship or extreme inconvenience. . . . ."

[6, 7] There is no merit to the defendant's contention. The trial court correctly held that the objection was not timely raised, since the defendants had not mentioned it until after the jury was impanelled. See Brooks v. United States, 5 Cir. 1969, 416 F.2d 1044, 1047. We also agree with his ruling that the jury selection plan was in compliance with the statute.

V.

Gumanis next objects to the trial court's refusal to instruct the jury that Donaldson's claim was barred by the statute of limitations.[49] This contention is premised upon the fact that Donaldson was taken out of his care April 18, 1967, more than four years before the filing of the First Amended Complaint in this case, and about five years before the complaint was amended to add Gumanis as a defendant.

Since there is no statute of limitations provided under § 1983, federal courts adopt the statute of limitations of the state where the action arose,[50] and apply the "resemblance test" to decide which state statute is an appropriate one to apply.[51] In this case, the parties agree that the limitation period should be taken from one of three state statutes: the two-year statute applicable to both false imprisonment actions and to actions for medical malpractice; or the three-year statute applicable to actions upon liabilities created by statute; or the four-year statute applicable to miscellaneous actions not specifically provided for elsewhere in the Florida statute of limitations chapter.[52] Gumanis argues that it is irrelevant which of these 3 periods we apply, since even if the

49. The instruction in question read:
You are instructed that the statute of limitations for the wrongs alleged in the complaint are for the period of four (4) years, and that the defendants should not be held accountable for any damages which occurred from wrongs occurring prior to the four (4) year period preceding the complaint.
Donaldson argues that the defendants' objection to the trial judge's refusal to give this instruction is not properly before this Court, again because no objection was made to the trial judge's failure to give the instruction either at the charge conference or after the charge was read to the jury. See note 8 *supra*. Again, however, defendants' pretrial brief advised the court of the defendants' position, and again we hold that that sufficed to excuse the failure to object. See note 8 *supra*.

50. Campbell v. Haverhill, 1895, 155 U.S. 610, 15 S.Ct. 217, 39 L.Ed. 280.

51. See, *e. g.*, Smith v. Cremins, 9 Cir. 1962, 308 F.2d 187.

52. Fla.Stat. § 95.11(4), (5)(a), (6), F.S.A.

BEST COPY AVAILABLE

longest, the four-year statute, is applied, the period of limitations had elapsed by the time Gumanis was added as a defendant in this suit. Donaldson agrees that it is irrelevant which statute is chosen, since the limitation did not begin to run until July 31, 1971, the date Donaldson was released from the hospital. Donaldson therefore argues that the suit was timely brought, even if the two-year limitation period applies.

[8–10] We agree with Donaldson that the limitation period, be it two, three, or four years, did not begin to run until July 31; Donaldson's cause of action did not accrue until that time. When a tort involves continuing injury, the cause of action accrues, and the limitation period begins to run, at the time the tortious conduct ceases. See, *e. g.*, Fowkes v. Pennsylvania R. R. Co., 3 Cir. 1959, 264 F.2d 397. In the case of false imprisonment, the tort action this case most resembles, the cause of action does not accrue until the release of the imprisoned party.[53]

[11] We have found no Florida decision addressing the question when a cause of action for false imprisonment accrues. But in a § 1983 suit, even though a state statute is applied, the question when a federal cause of action *accrues* is a matter of federal, not state law.[54] The state statute is applied in the first place not as a matter of legal compulsion, but merely as a matter of convenience; there is no other period of limitation available.[55] We hold that in a case such as

53. See, *e. g.*, Bronaugh v. Harding Hospital, Inc., 1958, 12 Ohio App.2d 110, 231 N.E.2d 487; Mobley v. Broome, 1958, 248 N.C. 54, 102 S.E.2d 407; Matovina v. Hult, 1955, 125 Ind.App. 236, 244, 123 N.E.2d 893; Bellflower v. Blackshere, Okl.1955, 281 P.2d 423, 425; Oosterwyk v. Bucholtz, 1947, 250 Wis. 521, 525, 27 N.W.2d 361; Jedzierowski v. Jordan, 1961, 157 Me. 352, 172 A.2d 636.

54. See, *e. g.*, Rawlings v. Ray, 1941, 312 U.S. 96, 61 S.Ct. 473, 85 L.Ed. 605; Cope v. Anderson, 1947, 331 U.S. 461, 67 S.Ct. 1340, 91 L.Ed. 1602; Sandidge v. Rogers, S.D.Ind.1958, 167 F.Supp. 553, 556; 2 Moore's Federal Practice ¶ 3.07(2) at 750.

55. See McAllister v. Magnolia Petroleum Co., 1958, 357 U.S. 221, 228–230, 78 S.Ct. 1201, 2 L.Ed.2d 1272 (Brennan, J., concurring); 2 Moore's Federal Practice ¶ 3.07(2).

this one, where a tort causing continuing injury is alleged, a patient's cause of action does not accrue until the date of his release.

VI.

[12] Gumanis next contends[56] that the district court erred in refusing to instruct the jury that he and the other defendants were entitled to a defense of quasi-judicial immunity under the Civil Rights Acts. At issue is defendant's proposed instruction number 11, which read:[57] "If you find that the defendants were operating in a quasi-judicial function, in that they, under state law, were making a judgment as to whether or not plaintiff should be released, defendants are immune from liability under the Civil Rights Act."

Gumanis relies primarily upon three Ninth Circuit cases. The first and most important is Hoffman v. Halden, 1969, 268 F.2d 280, in which the Ninth Circuit held that the superintendent of a state mental hospital, who allegedly had wrongfully detained a patient committed under a valid judicial commitment order, was immune from liability. The superintendent was empowered to release the patient when, in his own judgment, he found the patient no longer in need of confinement. The Court held that because he had been exercising a "discretionary" function, the Superintendent was immune from liability. The other two Ninth Circuit cases, Silver v. Dickson, 1968, 403 F.2d 642, and Keeton v. Procunier, 1971, 468 F.2d 810, held that members of state parole boards are immune from § 1983 liability, on the ground that the threat of liability would "exert a restricting influence on the overall functioning of the agency". *Silver*, 403 F.2d at 643.

56. Once again, Donaldson argues that the objection to the refusal to give the instruction is not properly before the Court. See notes 8, 49 *supra*. Once again, we hold that the trial judge was sufficiently apprised of the defendants' objections for us to consider the objection as having been preserved. See notes 8, 49 *supra*.

57. The full instruction is quoted in part III *supra*.

[13] Gumanis's argument is essentially that he is entitled to the defense, available to state officials in most common law jurisdictions, of absolute immunity for acts done in the performance of a "discretionary"—as opposed to a "ministerial" —function. See, *e. g.*, Barr v. Matteo, 1959, 360 U.S. 564, 79 S.Ct. 1335, 3 L.Ed.2d 1434 (immunity for federal officials as a matter of federal common law). For discussions of the common law rule, see Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 857–861 (Rives, J.); Anderson v. Nosser, 5 Cir. 1971, 438 F.2d 183, 198–200 (Goldberg, J.); modified en banc on other grounds, 1972, 456 F.2d 835; Carter v. Carlson, 1971, 144 U.S.App.D.C. 388, 447 F.2d 358, 361–365; 2 F. Harper & F. James, The Law of Torts § 29.10 at 1638–46 (1956). We must reject Gumanis's argument, however, because we have consistently held that the full range of officials immunities available at common law do not apply in actions brought under § 1983. Roberts v. Williams, 5 Cir. 1972, 456 F.2d 819, 830; *Anderson, supra*, 438 F.2d at 201; *Norton, supra*, 332 F.2d at 860–861 (dictum). In taking this position we have been joined by all the other circuits that have considered the question. *Carter, supra*, 447 F.2d at 365; Dalé v. Hahn, 2 Cir. 1971, 440 F.2d 633; Kletschka v. Driver, 2 Cir. 1969, 411 F.2d 436, 448; Jobson v. Henne, 2 Cir. 1966, 355 F.2d 129, 133–134; McLaughlin v. Tilendis, 7 Cir. 1968, 398 F.2d 287; Donovan v. Reinbold, 9 Cir. 1970, 433 F.2d 738.

Official immunity has been restricted under § 1983, because that provision is directed at actions "under color of any statute, ordinance, regulation, custom, or usage of any State or Territory", and provides that "every person" subjecting another to a deprivation of constitutional rights shall be liable. See Francis v. Lyman, 1 Cir. 1954, 216 F.2d 583, 587; *Jobson, supra*, 355 F.2d at 133; *Anderson, supra*, 438 F.2d at 201; *Hoffman, supra*, 268 F.2d at 300. It has been the view of the courts that recognizing broad judicial immunities "would prac-

tically constitute a judicial repeal" of § 1983, since state officers are likely to be the primary persons found acting "under color of" law. *Hoffman, supra*, at 300; *Jobson, supra*, 355 F.2d at 134. Accordingly, the courts have repudiated what the district court for the District of Nevada has called the "discretionary act test" for determining when official immunity is appropriate in § 1983 cases. Adamian v. University of Nevada, 1973, 359 F.Supp. 825, 834. Instead, we and other courts have applied what the *Adamian* court called the "good faith for qualified governmental immunity" test, allowing immunity when (1) the officer's acts were discretionary; *and* (2) the officer was acting in good faith. Here, as noted above, the trial judge instructed the jury to find for the defendants if it found the defendants acted in good faith; and, again as noted above, the defendants have not challenged the propriety or phrasing of this instruction. That instruction was all that was required by this Court's version of the doctrine of "quasi-judicial" or "official" immunity from Civil Rights Act liability.[58]

58. It is appropriate to say in this context that we do not view the *Hoffman*, *Silver*, and *Keeton* cases as sound authority for a contrary result. The Ninth Circuit has made it clear that Hoffman and Silver do not "stand for the broad principle that all public officials are immune from Civil Rights Act liability if their acts were discretionary and done within the scope of their official duties". Donovan v. Reinbold, 9 Cir. 1970, 433 F.2d 738, 744. The Second Circuit had earlier stated its view that it would have disapproved the *Hoffman* decision if that decision had to be read to mean that "all subordinate state officials should be granted an immunity for all discretionary acts". *Jobson, supra*, 355 F.2d at 134 n. 11. And we ourselves have already once stated our view that *Hoffman* represented a "questionabl[e] resol[ution]" of the problem of official immunity under the Civil Rights Act. Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 861 n. 9, (Rives, J.). To the extent that *Hoffman*, by implying that state mental health officials should enjoy some form of "quasi-judicial. immunity", is read as authority for a result contrary to the one we reach here, we decline to follow it. We rely instead on *Dale* and *Jobson*, where the Second Circuit held state psychiatrists and mental hospital officials were not entitled to immunity under § 1983.

VII.

[14] The remainder of the objections Gumanis raises pose little difficulty. Gumanis contends that the trial judge erred in allowing the jury to award punitive damages. The objection is without merit. The trial judge instructed the jury that it could award punitive damages if it found that the defendants had acted "maliciously", "wantonly", or "oppressively". The instruction was proper as a matter of law, and there was ample evidence, some of it recited in our statement of facts above, to support a jury finding that the defendants' acts were "malicious", "wanton", or "oppressive".

[15] Gumanis argues that Donaldson's failure to receive treatment was a result largely of his own refusal, on religious grounds, to accept certain forms of treatment, particularly medication and electroshock treatments, and his failure to petition for restoration of his competency under Fla.Statutes § 394.22, F.S.A. Neither argument has any merit. As for Donaldson's refusal of forms of treatment, the trial judge instructed the jury: "You are instructed that if Plaintiff through his own actions contributed to the withholding of a particular form of treatment, that Plaintiff is not entitled to collect compensation from the Defendants for the failure to give such treatment during the particular period or periods Plaintiff refused such treatment." Gumanis did not at the trial and does not now object to this instruction. We find no reason to believe that either the verdict or the award of damages was based upon the failure to give Donaldson those forms of treatment he refused. As for his failure to petition for a restoration of his competency, the statute in question does not permit a person adjudged incompetent to petition on his own for a restoration of his competency; the petition may be instituted only by a parent, guardian, or "next friend". Donaldson cannot be held accountable for not doing what he was legally unable to do.

Finally, Gumanis contends that "the cumulative effect of certain errors and irregularities during the course of the trial

was such as to significantly undermine the fairness of the trial itself". We have considered these alleged errors too, and find no merit to any one of them. We have also concluded, upon a review of the record, that cumulatively they did not affect the fairness of the trial to any appreciable extent.

The judgment of the district court is

Affirmed.

Adm. Office, U.S. Courts—West Publishing Company, Saint Paul, Minn.

United States Court of Appeals

FOR THE FIFTH CIRCUIT

October Term, 1973

No. 73-1843

D. C. Docket No. CA 1693

KENNETH DONALDSON,
Plaintiff-Appellee,

versus

J.B. O'CONNOR, M.D. and JOHN GUMANIS, M.D.,
Defendants-Appellants.

Appeals from the United States District Court for the
Northern District of Florida

Before RIVES, WISDOM and MORGAN, Circuit Judges.

J U D G M E N T

This cause came on to be heard on the transcript of the record from the United States District Court for the Northern District of Florida, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed.

April 26, 1974

Issued as Mandate:

Supreme Court, U. S.
FILED
DEC 17 1974
MICHAEL RODAK, JR., CLERK

APPENDIX

IN THE SUPREME COURT OF THE UNITED STATES

NO. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petition for Certiorari filed July 25, 1974
Certiorari Granted October 21, 1974

APPENDIX

IN THE SUPREME COURT OF THE UNITED STATES

NO. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Petition for Certiorari filed July 25, 1974
Certiorari Granted October 21, 1974

INDEX

	Page
Chronological List of Relevant Docket Entries	iii
Transcript of Proceedings:	
Testimony of Dr. Walter Fox, Witness on Behalf of Plaintiff-	
Direct Examination	1
Cross Examination	17
Recross Examination	30
Testimony of Kenneth Donaldson, Plaintiff-	
Direct Examination	31
Cross Examination	54
Recross Examination	58
Testimony of Dr. Raymond D. Fowler, Witness on Behalf of Plaintiff-	
Direct Examination	61
Testimony of Dr. John Gumanis, Witness on Behalf of Plaintiff-	
Direct Examination	75
Cross Examination	122
Reading of Interrogatories to Dr. O'Connor	127
Motion for Directed Verdict	140
Testimony of Dr. F. G. Walls, Witness on Behalf of Defendants-	
Cross Examination	141
Testimony of Dr. Clark Adair, Witness on Behalf of Defendants-	
Direct Examination	145
Testimony of Dr. W. D. Rogers, Witness on Behalf of Defendants-	
Direct Examination	147
Testimony of Dr. Jesus S. Rodriguez, Witness on Behalf of Defendants-	
Direct Examination	152

Reading of Deposition of Dr. O'Connor on written interrogatories..... 153
Oral Charge to Jury..... 173
Plaintiff's Exhibit No. 1..... 187
Defendants' Exhibit No. 4..... 242
Sections394.21, 394.22, Florida Statutes (1955)..... 243
Opinion of the Court of Appeals..... 257
Judgment of the Court of Appeals.... 304

CHRONOLOGICAL LIST OF RELEVANT DOCKET ENTRIES

February 26, 1971--Complaint seeking injunctive relief for violation of constitutional rights and petition for writ of habeas corpus.

March 10, 1971--Order denying petition for writ of habeas corpus.

July 26, 1971--Respondents Motion to Strike.

July 26, 1971--Defendants Motion to Set Aside Order.

July 27, 1971--Defendants Motion to Dismiss

July 29, 1971--Plaintiff's Motion for default judgment in the habeas corpus petition and complaint; or in the alternative, order defendants to answer complaint, permitting inspection of hospital record, for substitution of party defendant; to proceed as class action in habeas corpus petition and postpone deposing plaintiff.

August 2, 1971--Defendant's Motion to Dismiss.

August 16, 1971--Order (1) denying defendants' motion to set aside and vacate Court's Order of April 26, 1971 (2) granting motion of defendant Peter Ivory to dismiss complaint and petition (3) granting defendants motion to strike allegations with reference to action as a class suit and giving plaintiff 10 days to amend his complaint (4) denying defendants' motion to strike damage aspect of petition-complaint (5) granting defendants motion to dismiss petition-complaint to the extent that no cause of action has been properly alleged for recovery of damages and petitioners complaint is dismissed without prejudice

to plaintiff to amend complaint is dismissed without prejudice to plaintiff to amend within 10 days (6) granting motion to dismiss insofar as petition-complaint seeks declaratory and injunctive relief w/o prejudice to plaintiff to file a new and separate complaint seeking relief pursuant to 28 USC 2281 and denying all other aspects of the motion (7) granting motion of J. B. O'Connor for protective order and said defendant shall not be required to submit to oral deposition until he regains his health (8) denying plaintiffs' request for permission to interview incarcerees at the Florida State Hospital at Chattahoochee.

August 30, 1971--Plaintiff's First amended complaint.

September 9, 1971--Filed Defendants Emmett S. Roberts and Milton J. Hirschberg's Motion to Dismiss the action in their private and official capacities.

September 9, 1971--Filed Defendants Motion to Dismiss the complaint and amended complaint.

September 28, 1971--Motion of defendant, Virgil D. Smith, M. D., to Dismiss.

September 28, 1971--Defendant's, J. O. Norton, Motion to Dismiss.

November 8, 1971--Filed Plaintiff's Memorandum of Law in Reply to Defendants' Motions to Dismiss.

November 8, 1971--Motion of plaintiff for issuance of order making Milton J. Hirschberg, Emmett S. Roberts, J. O. Norton and Virgil D. Smith parties defendant her and directing the issuance and service of process upon them, nunc pro tun

November 19, 1971--Order pursuant to hearing on motions (1) denying motion of defendants Hirschberg and Roberts to dismiss the complaint for improper joinder of additional parties (2) taking under advisement plaintiff's application for 3 judge court etc. (3) dismissing complaint as to White and Jones (4) deny motions of defts Smith and Norton to dismiss cause and taking under advise other aspects of motions (5) denying motions of defendants O'Connor, Hirschberg, Roberts to dismiss them in their official state capacities and individual (6) dismissing amended complaint insofar as habeas corpus relief pursuant 28 U.S.C. 2241 et seq. (7) denying any other remaining pending motions (8) discovery shall be completed by Jan. 1, 1972 except that upon leaving court parties will be allowed to make such further discovery as becomes necessary (9) motion ore tenus of defendant Norton for the taking of deposition of plaintiff is denied until court has affirmatively determined whether defts Smith and Norton should remain parties to this suit.

January 5, 1972--J. B. O'Connor, M. D. Answer to Interrogatories.

January 10, 1972--Defendants O'Connor and Walls Objection to Interrogatories and Request for Admission.

February 8, 1972--Answer of Defendants J. B. O'Connor, M. D., individually and as former Superintendent of Florida State Hospital, Milton J. Hirschberg, M. D., individually and as Superintendent of Florida State Hospital, Francis G. Walls, M. D., individually and as former Acting Superintendent of Florida State Hospital and Emmett S. Roberts

February 9, 1972--Amendment of Complaint.

April 20, 1972--Order (1) granting plaintiff's motion to add John Gumanis, M. D., as an additional party defendant and directing plaintiff to have service of process on this party issued forthwith (2) granting motion of defendants Roberts, Hirshberg, O'Connor and Walls for order compelling discovery and directing plaintiff to comply with defendant's motion to produce and to furnish requested items for copying and inspection within 10 days and failing this, Court will impose such sanctions as are just and necessary (3) granting plaintiff's motion of 3/22/72 for order compelling defendants to answer interrogatories and requests for admission and defendants are directed to make discovery as requested by plaintiff and to answer in 10 days or as soon thereafter as possible; failing this the court will impose such sanctions as are just and necessary (4) taking under advisement motion of defendant Smith for entry of final judgment pending disposit of all issues.

June 1, 1972--Answer of Defendant John Gumanis, M. D.

June 26, 1972--Filed answer to Supplemental Interrogatories to Defendant O'Connor.

June 26, 1972--Response to Request for Defendant O'Connor to Admit.

August 7, 1972--Deposition of J. B. O'Connor, M. D., on Written Interrogatories.

October 5, 1972--Order granting motion for summary judgment and directed to Clerk to judgment in favor of defendants, Virgil D. Smith, M. D., and J. O. Norton.

October 5, 1972--Judgment on Decision by the Court in favor of defendants, Virgil D. Smith, M. D., and J. O. Norton, M. D.

November 7, 1972--Amended Responses to Interrogatories to Dr. O'Connor dated Oct. 13, 1972, in Reply to Telephone Request of Eugene Dubose on October 30, 1972.

November 7, 1972--Amendment to Answer.

November 16, 1972--Amendment to Deposition of J. B. O'Connor, M. D. on Written Interrogatories.

November 17, 1972--Deposition of Dr. J. B. O'Connor on Written Interrogatories taken November 16, 1972.

November 21, 1972--CASE CAME ON FOR TRIAL BY JURY of 6.

November 28, 1972--FILED in open court Jury verdict in favor of Defendant Francis G. Walls and against plaintiff Kenneth Donaldson.

November 29, 1972--FILED in open court jury verdict in favor of plaintiff and against the defendant J. B. O'Connor for punitive damages in the sume of $5,000.

November 29, 1972--FILED in open court jury verdict in favor of plaintiff and against the defendant J. B. O'Connor for compensatory damages in the sum of $17,000.00.

November 29, 1972--FILED in open court jury verdict in favor of plaintiff and against the defendant John Gumanis for punitive damages in the sum of $5,000.

November 29, 1972--FILED in open court jury verdict in favor of plaintiff and against the defendant John Gumanis for compensatory damages in the sum of $11,5000.

November 29, 1972--FILED Judgment in favor of defendant Francis G. Walls against Plaintiff.

November 29, 1972--FILED Judgment in favor of plaintiff and against defendant O'Connor in the total sum of $22,000.00.

November 29, 1972--FILED Judgment in favor of plaintiff and against defendant Gumanis in the total sum of $16,500.00.

December 8, 1972--FILED Motion for Judgment in Accordance with Motion for Directed Verdict.

December 8, 1972--FILED Motion for New Trial.

December 11, 1972--FILED Amendment to Motion for New Trial.

December 20, 1972--Notice of Appeal with Certificate of Service thereon to counsel of record.

January 29, 1973--Filed Notice of Appeal from final judgment of 11/29/72 by defendant Gumanis.

April 26, 1974--Opinion of Court of Appeals.

TRANSCRIPT OF TESTIMONY

11/21/72

TESTIMONY OF DR. WALTER FOX--DIRECT EXAMINATION

BY MR. ENNIS:

Q Dr. Fox, have you had occasion in your experience to examine hospital records of mental patients?

A Yes, sir.

Q Approximately how many?

A It would be in the hundreds, sir.

[65]

Q Has it been part of your responsibility to examine those records to determine whether or not they were adequate records?

A Yes, sir, this is a big part of the hospital surveys that I do as a consultant for the National Institute of Mental Health.

Q Has it been part of your experience to examine those records to determine whether or not the patients described in those records were receiving adequate treatment?

A Yes, sir, that is the purpose of the examination.

Q Now, I will ask you, Dr. Fox, have you had occasion to examine the hospital records of Mr. Kenneth Donaldson, the Plaintiff in this case?

A Yes, sir, I have.

Q Dr. Fox, based upon your professional opinion after your review of that record, I would like to ask you for the period 1957 through 1967, is there evidence in that record that Mr. Donaldson received psychiatric treatment?

A No. In my opinion there is not evidence that he received psychiatric treatment. There are a number of progress notes which are generally brief and which make no reference to a treatment plan which frequently refer to continue custodial care or words to that effect, which I

[66]

interpret to mean provide food, clothing and shelter, and that is not psychiatric treatment.

Q Again, for that period of time, Dr. Fox, is there any evidence in the record that Mr. Donaldson received any form of care or treatment that he could not have received in a prison?

A No, sir.

Q I am sorry.

A No.

MR. MAHORNER:

Wait.

BY MR. ENNIS:

[69]

to document evidence of schizophrenia if that is the diagnosis that has been given to a patient?

A Yes, sir.

Q Is there evidence in the record that Mr. Donaldson was physically dangerous to himself or to others?

A I could find no evidence anywhere to that effect, that he ever hit anyone or ever even threatened anyone verbally. There is one incident report that shows that another patient ran at him and he stepped aside.

Now, I believe there is one unsupported statement in a staff conference about 1964 attributed to Dr. O'Connor saying that this patient was incompetent and should be considered dangerous to others. Now, this was a conclusion, but as to the basis of that conclusion, I couldn't find anything in the record.

Q Dr. Fox, is it standard practice in mental hospitals to document in the patient's record every incident of dangerous or violent behavior?

A Yes, sir.

Q And you found no such incidents in this record?

A No, sir.

Q Dr. Fox, was there evidence in this record that Mr. Donaldson received an individualized treatment plan?

A No, sir, there was no evidence of that in those first ten years.

[70]

Q Was there evidence in the record that the hospital staff ever assessed Mr. Donaldson's strengths?

A No, there -- at least, let me again say for the first ten years, there was no evidence of this, and, of course, the major goal of a hospital is to get people out, and in order to do that you must build on their strengths, so this is a very important --

Q And why is that, Dr.?

A Well, you never get anyone out of a hospital if you concentrate on their deficiencies, on their problems.

Q Now, Dr., assuming the evidence in this case will indicate that for the first ten years at Florida State Hospital the Plaintiff was confined to a locked building and a locked ward and had no grounds privileges, would that be consistent with a psychiatric treatment plan for him?

A No, it would not.

Q Why is that?

A Well, there was nothing in his past history to indicate that he was likely to be dangerous to other people. There was nothing in his past history that showed that he wasn't a generally self-sustaining if frequent moving individual.

Everything would point to the fact that here was an individual who had made it pretty well, who was responsible, who did have regard for his fellow human beings,

[71]

and right off you look at this guy as somebody to get out of the hospital very soon, and one of the ways you would do that is by giving him as much freedom as possible as soon as possible.

Certainly confinement never improves psychiatric symptoms. It makes a suspicious person more suspicious, a depressed person more depressed, and another thing about being in confinement, by and large you are made dependant on the routine of the hospital.

You make no decisions about when to get up, what to eat, what to do next, when to go to bed, sometimes even such things as when to shower have been decided, and this will gradually rob a person of their independence.

Q Did that happen in this particular case?

A No, surprisingly, it didn't.

Q And what does that indicate to you?

A That Mr. Donaldson had a great more, great more internal strength than most of the people that would find themselves in that sort of total institution for that period of time.

Q Dr. Fox, in your professional opinion how reliable are psychiatric predictions of dangerous behavior?

A I used to think I could do it a lot better than I do now. Generally speaking, my experience over the years shows that we score poorly on predicting future

[72]

dangerous behavior, and by and large in hospital psychiatry we tend to see more danger than future events show to be true.

Q Dr. Fox, what is your professional opinion from reading the record concerning the hospital's efforts to discharge Mr. Donaldson?

A Well, it appears to me that for the first few years there was an almost indifference to discharge. It was almost as if this was not one of the hospital's goals, it just wasn't spoken to too much,

and then, let's say from 1957 to 1963 that seemed to bear out, then in 1963 I would have to say that there is some evidence that there was actual resistance to the discharge of Mr. Donaldson.

For instance, in June of 1963 an agency called Helping Hands wrote to Dr. O'Connor and explained their services.

They said they were a halfway house, and that they helped thousands of people like Mr. Donaldson, former transition back into the community, that they had been in correspondence with Mr. Donaldson and that they would like the opportunity to accept him into their program, and they received a letter back saying that by and large, as I recall the letter, this man needed a great deal of super-vision, which, of course, a halfway house is prepared to give, that released -- it should be back to his parents,

[73]

and bear in mind, now, these people are in their 80's, I think, at this point, and that under the circumstances a discharge to a third party at this point seemed ill advised.

Now, that seems like more than just indifference. It was an indication that Dr. O'Connor felt that this person should not be out.

On another occasion when a friend from New York State offered to come and get Mr. Donaldson and help him get back on his feet outside of the hospital, this man was actually discouraged. He was told he would have to get permission from the parents, which I believe he got, and then he had to get, tell, you know, more about himself, which he did, and then I believe it was a note written sometime in 1964 by Dr. O'Connor to, I think, the attending physician, to the effect that anyone who would want to take Mr. Donaldson into their home must not be too well, himself.

Q Let me ask you, Dr. Fox, on this, you mentioned the halfway house. Would you please briefly explain to the Jury what a halfway house is?

A Well, it is just really what the name implies. It is a passageway between, or a stepping stone, perhaps, between, let's say, a total institution where a person has spent twenty-four hours, and an independent living situation.

There are many more stepping stones that one could use, but, and let's just give as an example, that a

[74]

person would go from twenty-four hour care in a mental hospital to a halfway house where they would be able to sleep at night and maybe have some help

but what I would like for the doctor to talk about is the date of the letter and then how long thereafter he was discharged, which is now evident from the face of the letter.

THE COURT:

Which is not what?

MR. ENNIS:

Evident from the face of the letter.

[77]

THE COURT:

Well, there is evidence, though, as to when the man was discharged and will come out, is there not?

MR. ENNIS:

Yes, sir, Your Honor.

THE COURT:

I think an answer to that question would be objectionable.

BY MR. ENNIS:

Q All right, Your Honor, I will withdraw the question, then.

Dr. Fox, you testified you had examined hundreds of hospital records of mental

patients. Would it be one hundred, two hundred, nine hundred? Can you give a closer estimate?

A Oh, five hundred. You see, when we make these surveys, we usually examine about thirty records right there, so within the last two and a half years, I guess I have made fifteen of those surveys, so you can calculate that at maybe four hundred or five hundred records that we have surveyed within the last --

Q Within the last two years?

A Yes, sir.

Q Now, in your professional opinion was Mr. Donaldson's hospital record an adequate hospital record?

[78]

A No, sir.

Q Could you just tell the Jury, if you would, some of the deficiencies?

A Well, basically there was at no time except for perhaps two months in 1967 evidence of a treatment plan. Now, a treatment plan is basic to discharging a person.

A treatment plan is where you list some of the problems to you goal of getting a person out of the hospital. You list

the assets, the strengths, the things that can be built on, and you indicate who is going to be responsible for trying to develop some of these assets, and overcome some of these problems.

You may have some short term goals, like a person is sleepless, trying to get over that, some long term goals, like resolving a family conflict or a job situation, or something like that, but it really is basic to have a treatment plan, have a group of people working together to a goal, and then to have progress notes that speak to that treatment plan, you know, how is it coming, if it is coming well, fine, if it is not, then we change it.

So the lack of a treatment plan, the nature of the progress notes, the long intervals sometimes between the progress notes, I think in the first ten years there were fifty progress notes, which works out to about two and a half months each, but these would be as close together as a week sometimes and as far apart as fourteen months and

[79]

six months at other times.

Q Now, Dr. Fox, is it standard practice in mental hospitals for a psychiatrist or physician or psychologist to enter a note in the hospital record everytime he has a significant contact with the patient.

A Yes, sir.

Q Did the report indicate how long Mr. Donaldson had been at the hospital before he was first presented to a staff conference?

A Yes, sir, it did. He arrived in 1957. As I recall, the first staff conference was in 1962. I may be incorrect in that, but it was a considerable period of time.

Q Now, Dr. Fox, assume that the evidence will show that Florida State Hospital had low staff and had limited financial resources, given those limitations, could something positive, nevertheless, have been done for Mr. Donaldson?

A Yes, I think so, and I think the vital thing would have been for the admitting person, admitting physician to have spotted this man from his history as a person to stay in the hospital, but a short period of time to have communicated to the rest of the staff working with Mr. Donaldson, and to have immediately embarked on a program which would have emphasized continuation of the community ties, in this case, with his parents who were not too far

away, or if he didn't want that, to change it and start building ties perhaps to a job situation somewhere.

Q How could that have been a help?

A Well, by reading the want ads for one thing. If he, as this man said, I believe at one time that he wanted to move to someplace, establish himself in a town in the north, one of the methods of helping out with that, particularly with this man's ability to find jobs, would be to provide him with a paper from one of those areas.

Q What do you mean when you talk about this man's ability to find jobs? Would you elaborate on that, please?

A Well, yes, something that I saw in the record many times was that he was a floater, that he was always leaving jobs. Well, that is the opposite side of the coin. The other side of the coin is that he was always finding jobs and that he was not a welfare case.

Q Dr. Fox, given an institution with limited resources, would it still have been possible to give Mr. Donaldson grounds privileges?

A Of course.

Q How about weekend passes?

A Yes.

Q Or trial visits for a week or month or two?

A Surely.

[81]

Q And would that be the standard psychiatric practice?

A Yes.

Q Given --

A In the case of Mr. Donaldson.

Q Given the limited resources of the hospital, would it have been possible to assign him to an occupational therapy department?

A This would have been excellent.

Q It would have been what?

A This would have been excellent because in some of the social history given by his parents there is an indication of a musical interest and artistic interest and here would have been a way to let him express himself, gain self-esteem, and so forth, and so on.

Ten years after his admisstion he was assigned and he did some pretty good painting apparently because there is some indication in the chart there that he was able to sell some of his paintings, so this would be --

Q Now, could you please describe to the Jury the function of the meaningful work program in an institution with limited resources?

A With limited resources, by that, do you mean no ability to perform a vocational rehabilitation function?

Q No, let me rephrase the question. What I am

[82]

asking you is were there any types of jobs or work at Florida State Hospital that Mr. Donaldson could have been assigned to that would have been a positive benefit to him?

A Well, he listed his means of livelihood as painting and carpentry, and perhaps if the hospital had a master carpenter, he could have not only maintained that skill, but learned some more, things like that are good, just so long as you don't exploit the patient in the process.

Q Now, Dr. Fox, I believe you testified that it was ten years before he was assigned to an occupational therapy program. Is there any evidence in the record that during that first ten years he was refused permission to go to an occupational therapy program?

A I must confess I don't know. I read somewhere on one occasion that he was refused, but I don't remember whether it was within the first ten years or not.

Q All right, now, Dr. Fox, given the positive steps that could have been taken to treat Mr. Donaldson even in an institution with limited resources, how long do you think it would have been necessary to confine him?

A Oh, I would guess possibly two months.

Q No longer?

A I shouldn't think so. I might say here that a guess of two or three months is presuming that the hospital employs a staff meeting involving several physicians to make

[83]

a simple decision like discharge on the average patient.

I don't think that that should have been necessary in the case of Mr. Donaldson. It wasn't that complicated a case.

Q Let me see if I understand your testimony. Are you testifying that if a staff of doctors had to make the decision to release him --

A It might take two or three months.

Q This would take two or three months, but if only one physician was responsible for that, how long would you say?

A It probably would take less. It should take less.

MR. ENNIS:

I have nc further questions.

CROSS EXAMINATION

BY MR. MAHORNER:

Q Dr., I have to ask you a few questions, if you don't mind. When did you first see the Defendant? Excuse me. When did you first see Mr. Donaldson?

A Last night when I got off the plane.

Q When did you first receive the hospital record?

A I received the hospital record approximately two weeks ago, sir.

[84]

Q Now, did you treat any patients yesterday?

A No, sir.

Q How about the day before?

A No, sir.

Q Have you treated any patients in the last week.

MR MAHORNER:

I apologize. I assure you it is unintended.

THE COURT:

I am sure you are not doing it intentionally because it tends to show that you don't know the difference.

MR. MAHORNER:

I understand. Right.

THE COURT:

All right.

BY MR. MAHORNER:

Q When did you first receive a psychological record?

A They came at the same time as the rest of the records.

Q As a separate package?

A As I recall, there was several pages, but the psychologicals were not separate. They were a part of, you know, one package, one of two or three packages.

Q But you never received a separate package of

[90]

psychological records?

A Not a separate package of them, no. I saw the psychological reports which were all pretty much in sequence, as I recall.

Q You saw the ones that are in the hospital records now?

A Yes sir.

Q Did you see anything in the record as to any test being done by an outside psychologist not associated with the institution?

A I saw a reference to that. I don't recall seeing the results of his test.

Q Did you see any instrument stating his findings or opinions?

A If I recall correctly, and I sure could be wrong on this, there was reference that an outside psychologist had found evidence that he might be dangerous, or it was some negative remark.

Q But you found no instrument that purported to be from that psychologist himself in the record?

A No, sir.

Q Did you see any evidence that Rorschach tests were made?

A Yes, sir, a number of the psychological reports indicated what tests were made.

[91]

Q Did you see the tests, themselves?

A No, sir.

Q Now, you stated the man had done pretty well. Do you know if he was ever in the service?

A I don't believe he was, sir.

Q Do you know if he was turned down for any reason of any incapacity?

A I don't recall from the record that that was mentioned one way or the other, but I will leave it at that.

Q Did you see anything that indicated who committed him?

A Yes. His parents requested his commitment, and two physicians whose names I don't recall signed the form.

Q Okay, do those physicians appear to be unattached to the institution?

A Yes, they did.

Q Was there a diagnosis in the form?

A Yes. As I recall, it was paranoid schizophrenia.

Q Was there any reference to a prior incarceration in the record -- excuse me. I will correct that, a prior hospitalization?

A I don't remember whether there was in the commitment papers, but there certainly was in the hospital

[92]

record. It was mentioned a number of times and there was even a letter from -- I think it was the Marcy Hospital detailing his hospitalization there for about three months in 1943, I believe.

Q Was the term dementia praecox or schizophrenia used?

A Yes, dementia praecox was.

Q Was that term used back then which has the same meaning as paranoid schizophrenia?

A Yes. Well, it has been the same meaning as schizophrenia.

Q Do you know anything about the job record of the Defendant prior to hospitalization?

A Only tnat he changed jobs frequently. To the best of my knowledge, he was never on welfare. At one time he ran a little business of his own, I believe with his father, and that he listed carpentry and painting as two of the things that he did, carpentry and painting.

I think there was some mention that at times he would help build the parents house or fix it up. There was frequent mention that he was moving, moving, moving, but not too much as to the specific nature of the jobs he held or for where or for how long.

Q Was there any indication that he moved because he felt his coworkers were against him?

[93]

A Yes.

Q Was there any indication as to who initiated the proceedings for Marcy?

A I think it was his wife.

Q Do you know if the marriage continued?

A It did not. She divorced him in 1949, according to the record.

Q Do you know as to whether there was any type of semi-traumatic academic experience early in, approximately when the Plaintiff was 21 or so?

A No, sir, I don't. I know that he started college and that he did not finish college. The record in various places says one and a half years and in other places it says two years, and it also says that he stopped college and lived around the house for a while.

Q Do you have any knowledge as to the behavior pattern or other reasons which may have caused the wife and/or the mother and father the other time to initiate this type of proceeding?

A I really don't know why the wife did. Mr. Donaldson says something to the effect that he couldn't blame her, you know, she didn't know what she was doing or didn't understand, and I might imply from that that she was advised to do it.

Now, as far as the other instances are

[94]

concerned, the parents said that he thought somebody was poisoning his food, to the best of my recollection, and that apparently alarmed them enough that they proceeded.

Q Do you know whether or not he was treated in Philadelphia or went to a hospital there?

A I missed that if it was in the record. I recall his going to Travelers Aid or something, some mention of that in Philadelphia.

Q Was that concerning a mental condition?

A I am not clear on that.

Q Does the judgment as to whether a person

is to be released from a mental institution involve factors that have to be considered both as to release and as to against release? In other words, is there a way when you start to make this decision as to the interest of the public and the interest of the patient, or is it just a matter that you feel the patient's interest can best be served by release and then you make the decision?

A Well, I think your obligation is to your patient, but I cannot foresee of urging release of the patient that would be to the detriment of the public because that would come right back to haunt your patient.

THE COURT:

I don't want to rush you, Mr. Mahorner, but you are taking too much time. Let's move along.

[95]

BY MR. MAHORNER:

Q In 1957 what was the best medical treatment plan that could have been given for the man?

A In 1957 I would have proceeded as I mentioned earlier, pegging him for an early discharge, letting the folks on the ward know that, giving him as much freedom in the meantime, keeping those ties with the community as strong as

possible, and if things went well, that is what I would have done.

Q Did you see any indication in the record that he refused treatment?

A I saw an indication in Dr. Adair's admission note that he didn't want to have electroshock treatment and I think Dr. Adair added that he didn't think it would do much good anyway.

There was one other or perhaps more than one other place where Mr. Donaldson mentioned a feeling towards Christian Science and a wish not to receive medication. This is a wish that in 1957 for a while, if things went well, I would have certainly have respected. There might have come a time when I would have and hopefully after trust had been built up where the man could have been persuaded to take the drugs.

Ten years later this was tried briefly, which I think is perfectly indicated, except that probably he

[96]

should have --

Q Now, if drugs had been received by him initially this would have been a form that you would not generally receive in prison, is that correct?

A If the drugs had been received originally, no, I wouldn't go that far.

assault, I know that. Perhaps it was that they were calling him homosexual. I remember the reference to homosexual on two or three occasions.

Q Now, on the question of standard practice put in the hospital record, if you were in an institution wherein there was like one physician, say, for 180 or 200 patients, in general each contact of the patient, whether or not it could be in the hospital record, or would

[100]

it be a matter that they might emphasize the treatment or contacts in the record by itself?

A Particularly when you have a very low physician to patient ratio, the hospital bylaws should allow other people to contribute to the progress notes and the hospital bylaws should also indicate an outside limit or the intervals of these progress notes, so, no, in answer to your question, but every single contact would be recorded, but every month or at least and more frequently is something unusual occurred, one of the members of the treatment team would undertake to summarize what had taken place in the form of a progress note and he would relate it to the treatment going to that patient.

Q Is there any recognized physical laboratory test for schizophrenia?

A No, sir.

Q Are there theories in that area?

A Yes, sir, a number of them.

Q How was the diagnosis generally established absent physical tests?

A The diagnosis is established on the basis of a thorough going history of the person's past life, sort of a longitudinal history of things and then a cross sectional history, namely, how the person is today, what does he look like, what does he talk about, how does he feel, what is his

[101]

judgment like, how does he perceive reality, and in addition to that there are psychological tests that can be used, and in a twenty-four hour setting you can add a lot of other things, such as how this individual relates to a social group, at a dance, or what he does in the occupational therapy department may reveal him.

Q Are there frequent disagreements as to diagnosis among the staff themselves? Can I change that question, Dr.? Dr., would disagreement be extremely rare or would it happen fairly often?

A Well, is this a general question or does it relate to this specific --

Q Yes, sir. It does not relate to specifics, a general question.

A I would say generally it would not be infrequent for people to hold different opinions, particularly early in their experience with an individual.

Q Did you look at the staffing of Mr. Donaldson in 1964?

A Yes, sir.

Q Were there doctors in excess of the two or three on that staff?

A Yes.

Q Did they all conclude that at that time he was mentally ill or a paranoid schizophrenic?

[102]

A They all concluded he was mentally ill, and the diagnosis I cannot recollect. If I was to guess I would say yes, paranoid schizophrenia.

MR. MAHORNER:

I would like to have a minute, Your Honor.

THE COURT:

Yes, sir.

is that correct?

A Yes, sir, except I think he was referring to a hypothetical person rather than Mr. Donaldson.

Q Let's assume if we change the hypothetical and that there is no evidence that he was ever rejected from military service, and that there is no evidence that he was ever in a mental hospital in Philadelphia, would it then be consistent with your understanding to assume an even shorter period of hospitalization?

A It would weigh in that direction, yes.

Q Now, Mr. Mahorner asked you some questions

[106]

about a thing called schizophrenia.

Is one of the major symptoms or indications of schizophrenic an inability to communicate with other people?

A I guess frequently it is.

Q And did you see any evidence in this record of that symptom from Mr. Donaldson?

A I certainly did not.

Q I believe you testified that you saw no

evidence in the record that would support a diagnosis of schizophrenia. Let's assume for the minute that the hospital's diagnosis of schizophrenia was correct. Let's assume that a minute, although I know I don't find any evidence to support that, even if that diagnosis of schizophrenia was correct, do you see any evidence in the record that would justify confining him to Florida State Hospital for fifteen years?

A No.

MR. ENNIS:

No further questions, Your Honor.

MR. MAHORNER:

I have a couple of recross.

RECROSS EXAMINATION

BY MR. MAHORNER:

Q I will ask you to look in the record. That

[107]

is a 1964 discharge -- excuse me, 1964 staffing. How many doctors do you see on that staff?

A One, two, three, four, five, six.

Q Now, what happened at the end of that ten day observation period?

A I thought I was going home. I had seen a doctor one time near the end of the ten days, talked to this

[175]

doctor for a few minutes, and the doctor didn't say one way or the other, but the fellow patient said, well, you will be going home tomorrow.

I thought I was going home, back with my family and back to work.

Q But did you go home?

A I did not.

Q Where were you taken?

A I was put in a van with some other people and taken to the state hospital nearby at Marcy.

Q How do you spell that?

A M-A-R-C-Y. It is near Rome, New York.

Q At that point you were an involuntary patient?

A That is right. I objected.

Q You objected to that?

A I objected.

Q Now, Mr. Donaldson, during the three months you were at Marcy State Hospital, what type of treatment was given to you?

A In the first place, the second day I was there I was put in an open ward and I had the privilege of the grounds all of the time I was there.

Q Yes.

A The doctor came through the ward everyday. He didn't have time to stop to talk to us, but a couple of

[176]

days I would walk along beside of him and ask him about going home.

Do you want me to tell everything that --

Q Well, let me just ask you this. Did you ever receive electroshock therapy?

A Yes, sir, I did.

Q That is also referred to as electro-convulsive therapy?

A That is right.

Q Now, did you go yourself to those electroconvulsive therapy sessions or

were you taken there?

A I went voluntarily.

Q And for how many of those did you go?

A Twenty.

Q And those were given over a period of approximately three months?

A They were given two a week, and the last week, the week of the last one I went home from the hospital. I drove the car home from the hospital.

Q Now, Mr. Donaldson, after you were discharged from Marcy State Hospital in early summer of 1943, were you ever again a patient in a mental hospital between that time and the time you were admitted to Florida State Hospital?

A No.

Q Now, with the exception of those two

[177]

hospitalizations, the Marcy State and Florida State, at anytime in your whole life have you ever been hospitalized as a mental patient?

A No.

Q Mr. Donaldson, would you please explain briefly to the Jury what you did with your

My home was where I hung my hat. I paid my bills, never asked charity, never caused any trouble, and I

[179]

thought it was my privilege as an American citizen to go anyplace in this country and work at any job that I cared to.

Q Let me ask you this question, Mr. Donaldson. You said you never caused any trouble. Let's be more specific.

Have you ever been convicted of any crime?

A No.

Q Have you ever in your entire life injured or threatened to injury yourself?

A No.

Q Or any other person?

A No.

Q You are absolutely sure of that?

A I am positive of that.

Q Now, Mr. Donaldson, where were you living in late 1953 and early 1954?

A Los Angeles.

Q Were you employed at the time?

A Yes.

Q Where did you work?

A Northrup Aircraft.

Q What kind of work did you do there?

A I was working in the warehouse in Lynnwood, later moved over to one of the towns on the border, on the coast.

[180]

I was rated as a crater and packer. My job was to cut the wood for the crates from the blueprints and the other man made the crates and packed the airplane parts.

Q Now, Mr. Donaldson, while you were in Los Angeles in late 1953 and early 1954, did there come a time when you experienced any particular difficulty?

A Yes.

Q What was the nature of that difficulty?

A They were of a physical nature, being in very good health most of my life when I experienced something that seemed a little bit unusual, I decided to do something about it.

Q What did you do about it?

TRANSCRIPT OF TESTIMONY

11/22/72

would pull out his 3 x 5 file card and ask me what ward are you on, and I would tell him, and he would ask, are you taking any medication, and I would tell him no. Are you working anyplace, and my answer was no, and then that was all.

One time when I came back after the escape, which was a particularly outstanding interview for me, he called me down.

When I came back I took a shower, I scratched myself pretty badly in my legs going through brambles and the attendants reported the scratches and so I was called down.

He came to the office and Gumanis said drop your pants. I did. Several years later when I complained about not getting any psychiatric consultations he pulled

[242]

out his 3 x 5 card and he read off all of the dates that he had seen me, including that date when he told me to drop my pants. He said those were psychiatric interviews, psychiatric treatment.

Q Mr. Donaldson, during the nine years that Dr. Gumanis was your attending psychiatrist, what was the total amount of time you spent talking with him?

A I would say it couldn't have been over two to four hours. I would say it would be closer to two hours. I have

no way of estimating it accurately.

Q Now, during your entire period of hospitalization, did Dr. O'Connor or Dr. Gumanis ever ask you what you considered your strengths to be, your strong points?

A No.

Q Pardon Me?

A No. No, sir.

Q Did either Dr. O'Connor or Dr. Gumanis ever tell you what they considered the short range goals for you to be?

A No.

Q Did they ever tell you what they had in mind as the long range goals for you?

A No.

Q Did Dr. O'Connor ever discuss group therapy with you?

[243]

A No.

Q When was the group therapy first made available to patients in your department?

A I don't remember the year, exactly, but it could have been around 1964 or 1965.

Q Did you go?

A No.

Q Did Dr. Gumanis ever explain to you what group therapy would do to improve your condition?

A No.

Q Did Dr. Gumanis ever tell you who would run the group therapy sessions?

A No.

Q All right, let me ask you this question, Mr. Donaldson.

Did Dr. O'Connor or Dr. Gumanis ever refuse to see you when you requested permission to speak to them?

A Many times.

Q One of them or both of them?

A I beg your pardon?

Q Was it just Dr. O'Connor who refused to see you?

A Both Dr. O'Connor and Dr. Gumanis, from a period -- it was late or sometime in May of 1957, which would have been the third month I was on the general ward.

Neither Dr. Gumanis nor Dr. O'Connor ever say me at my request from that time until the time I left the hospital.

After the first few years, I stopped asking, but they never say me for all of those years at my request, and during those years there were a few things that I wanted to discuss with them.

Q All right, now, did there ever come a time later on when you did talk with Dr. Gumanis, though not at your request? He called you down to the office?

A Yes, when he called me down to the office, yes.

Q Let me ask you this. Did you ever discuss with Dr. Gumanis his refusal to see you on those occasions when you requested to see him?

A Yes.

Q What did he say?

A He said he talked only to the patients that he wanted to.

Q And that was the substance of that discussion?

A I beg your pardon?

Q And that was essentially the substance of that discussion?

A That's right.

Q I would like to talk for a little while,

[245]

Mr. Donaldson, about the living conditions at Florida State Hospital.

A About which?

Q The living conditions.

A All right.

Q How many patients were there in Department A while you were there?

A When I went there in 1957 there were about 1,300. When I left ten years later it was 1,000 or less.

Q How many psychiatrists were there for that department?

A There was just one so called psychiatrist when I went there, and for a period of six months or so during the ten years there was at one time three, I believe. Generally, there was just one.

Q Now, in the buildings you lived in Department A, were those buildings locked?

A Yes, sir.

Q Were the wards you lived on locked?

A Yes.

Q Were there metal enclosures on the windows?

A Yes, padlocks on each window.

Q Approximately how many beds were there in the rooms where you slept?

A Sixty some beds.

[246]

Q How close together were they?

A Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.

Q Did you have chairs in the dormitory areas?

A There wasn't a chair in the room I was in.

Q All right, was there an outside exercise yard for your department?

A Yes, there was a space outside the building, a good sized space enclosed with a cyclone fence topped with barbwire.

Q Did you go out to that exercise yard?

A I went out from time to time when the other patients went out.

Q Was there ever a period of time when

you did not go out to the exercise yard?

A Yes, there was one period in particular when nobody went out for two years.

Q Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?

A That is right.

Q Were there criminal patients on your ward?

A There were criminal patients on the ward.

Q Approximately what percent of the population on your ward were criminals?

[247]

A Looking back, roughly, I would say a third. I do not know the figures for the whole department.

Q Let's just talk about your ward.

A Okay. I would say about a third in the wards I was in.

Q Now, did you sleep in the same rooms as the criminal patients?

A Yes.

Q Did you get up at the same time?

A Yes.

Q Did you eat the same food?

A Yes.

Q In the same dining room?

A Yes.

Q Did you wear the same clothes?

A Yes. The entire operation of the wards I was on was geared to the criminal patients.

Q Let me ask you, were you treated any differently from the criminal patients?

A I was treated worse than the criminal patients.

Q In what sense were you treated worse?

A The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.

Q For the criminal?

A On the criminal patients, and that would be

[248]

a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.

Q Was there a place on the ward you had access to for keeping personal possessions?

A No, not at that time.

Q What did you do with your personal possessions?

A I kept mine in a cedar box under the mattress of my bed.

Q Was there a place in the wards where you could get some privacy?

A No, not anytime in all of the years I was locked up.

Q Were you able to get a good nights sleep?

A No.

Q Why not?

A On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night.

They never did, but you think about those things. It was a lunatic asylum.

Q Mr. Donaldson, let me ask you a few questions

[249]

about employment or jobs you had at Florida State Hospital.

Now, when you first were transferred to the general wards, did you volunteer to work?

A I volunteered to work.

Q Why did you do that?

A I was told that was a way to get out, to show that you were willing to cooperate.

Q Now, were you assigned to a job?

A I was assigned to a job in the kitchen, the general kitchen.

Q Who assigned you to that job?

A Dr. O'Connor.

Q Did he talk to you about that particular assignment?

A No.

Q Did he talk to you afterwards about that particular assignment?

A No.

Q What were your duties in the kitchen?

A The first week I was there I took care of several tables. I cleaned them after

the meals, dumped the garbage and then we mopped the floors.

After I had been there about a week, I was put in charge of one of the steam tables. There are two steam tables.

[250]

It was my job to see that the steam tables were set up with the proper food and then I helped serve the food.

Would you like to know about the food that we had?

Q Sure. Tell the Jury.

A Generally, because I had some intelligence I was put in charge of dishing out the meat. The specialty of the house was bone stew. Sometimes we had it twice a day.

We never had a day without it, and when that was hot in the steam table you couldn't stand the stench.

I had to stand like this to serve it. That is what the people had to eat.

Another thing that I saw about the food was the man who served the butter. We didn't have butter everyday. It was called for two meals a day. This one man --

Q Was he a patient?

A He cut the butter, it was in --

Q Was he a patient or employee?

A He was a patient.

Q All right.

A And shortly after I worked at this time, I worked in the kitchen, he went to the T. B. Hospital. He was the type of person that never washed his hands.

Another thing about the food at this time,

[251]

there were circles of green mold like that on the bread. The meat was rancid. Some of the food was good, but most of it was unpalatable.

Q Did you have any responsibility for checking the menus?

A Yes.

Q All right.

A The menu for every meal was posted on the bulletin board in the kitchen and a copy was sent here to be put on file in Tallahassee.

My job when I started on the steam table, I was instructed to check the menu posted and what was sent to the

steamtable.

The first day I said we have not got such and such. We probably got -- we had bone stew that meal, for instance, instead of roast beef or something like that.

I reported that to the lady in charge. She said that is all right.

The next meal we didn't get the butter that we were supposed to, and I told her, and she said that is all right.

One more meal they switched the vegetables, we probably had blackeyed peas instead of a fresh vegetable, and I told her that, and she said that is all right. I never told her I know --

[252]

Q What were your working hours on that job?

A From 6:00 o'clock in the morning to 7:00 o'clock that night. I didn't work all of that time, but we were locked in the kitchen all of that time.

Q How many days a week?

A Seven days a week.

Q Were you paid anything?

A No.

Q How long did you work that job?

A Until the middle of the first year there.

Q And then what did you do?

A Then I wanted to work outside. I had never worked, been confined. I wanted to get outside on the grounds, so to be transferred to a job I had to quit this one.

They wouldn't transfer you while you were on a job, so I quit the job and stayed out in the yard one day, and sent a request to the doctor and I was put on outside detail.

Q Now, did any doctor discuss that job with you before you were assigned to it?

A No.

Q Did any doctor discuss how that job would relate to your treatment plan?

A No.

[253]

Q What were your duties on that job?

A We did everything that somebody else didn't do. We planted flowers, and strawberries that I told you about. We trimmed trees. I did carpentry, dug ditches, made plumbing repairs and

painting, and so forth, and watered the lawns.

Q How many hours a day did you work at that job?

A We were on the job three hours in the morning and three in the afternoon.

Q Did you get paid?

A No.

Q How long did you hold that job?

A Until I escaped in late December, early December.

Q All right, now, when you came back they kept you in a locked ward from then on, is that correct?

A That is right. They put me on the so called back yard.

Q What is the back yard?

A The back yard consisted of a building of four wards, two which contained the patients who were the furthest gone.

There are some people who are entirely out of their minds. They were there and they were also used as punishment wards. I was put back there.

Q What did you do?

A And I volunteered as a house man.

Q What did you do as a house man?

A Made beds, scrubbed the floors, washed the walls and assisted the retarded people to take showers and things like that.

Q Did you get any pay for that?

A No.

Q Did any doctor talk to you about that job assignment.

A No.

Q How long did you perform that job?

A There and after I was transferred to the front yard until the middle of the following year.

Q Now, did there come a time when you quit working?

A Yes.

Q Approximately when was that?

A That was in the summer of 1958.

Q Why did you quit work?

A I looked around, observed my fellow patients and the ones who seemed to get the most respect from the attendants

Q Did Dr. O'Connor ever tell you what he thought the medication would do to improve your condition?

A No.

Q Did Dr. Gumanis?

A No.

Q Did Dr. O'Connor ever try to persuade you to take medication?

A No. Dr. O'Connor respected my belief in Christian Science. He told me as long as I did not cause any trouble on the wards I wouldn't have to take medication.

Q All right, did Dr. Gumanis ever try to persuade you to take medication?

A One time.

Q Describe that, please.

A I was called down to Dr. Gumanis' office to

[258]

have a conference with him, and Dr. Rich, the Clinical Director.

I went over certain parts of my case. Dr. Rich turned to me and said you will have to take medication, and he said I will promise you this, if you will take medication for six months and then wait

another six months, I will release you from the hospital.

He said I will guarantee this, and Dr. Gumanis at that time said go on, Kenneth, he says, take it, you have tried other things, go on, try the medication.

Q Okay. I would like to ask you a few questions, Mr. Donaldson, about staff hearings or staff conferences.

What is a staff Conference?

A A certain number of the doctors at the hospital, the times I were there, I would say about eighteen doctors sat around a long table. The doctor who was presenting the patient sits at the end of the table with the patient.

Q Are those staff hearings regularly scheduled for patients?

A They are regularly held, yes, probably every week. I imagine every week for each department.

Q I am not asking you if the hearings were every week. I am asking you does a patient get a staff conference at regular intervals automatically?

[259]

A No.

Q Was that up to his attending doctor?

TESTIMONY OF KENNETH DONALDSON - Cross Examination

Could you give us a page reference, please?

MR. MAHORNER:

No, sir, I am sorry. When you said hospital record, it is in the Marcy State Hospital record.

MR. DEAN:

What page of that, sir?

BY MR. MAHORNER:

Q It is the first page, sir. Do you recognize

[294]

your handwriting there?

A Yes, sir, that is my handwriting.

Q I will ask you to read the third paragraph of that letter, sir.

A I maintain that the misuse of political powers was the sole reason that I was given the course of electroshock treatment, not misuse on my part, naturally, as I never had any powers, but at the direction of someone in the General Electric Company or in the state government at the time or in the national government at the time.

Q Now, that letter was written many

years after you left Marcy, wasn't it, or what year was it written?

A That was written in 1954.

Q Do you recall that paragraph?

A I do.

Q What type of political power was involved in your incarceration at Marcy, sir?

A Again, I will ask you, do you want my belief or do you want a statement of fact?

Q I am willing for you to give your belief.

A My belief. I believed that someone objected to remarks I had made about the conduct of the war. I have no exact memory of what happened at that time. I have no way of knowing how much of my memory returned after I got the electroshock treatments. I maintained that statement as a

[295]

belief at that time. I had no facts.

Q Would you look at this letter showing the signature, Kenneth McCullough, sir, which is the second letter in that record?

months in a New York State Hospital.

[317]

New York Hospitals were at that time infested with Communists and in a generally disorganized condition similar to the one prevailing in Chattahoochee up to this year.

I was subjected there to some psychiatric horseplay which left me a mental partial cripple for about ten years.

Q Go ahead, please, sir.

A Before I was completely cured I was introduced to Christian Science which I give full credit for my excellent health today.

Q Did you go on to say that politics was entirely responsible?

A I beg your pardon?

Q Did you go on to say that politics was entirely responsible?

A In the following years I began the reading of law in my spare time and took an interest in politics. Because of the latter I was subjected to -- I was subjected to ridicule when the report of my former hospitalization became broadcast.

Q Go ahead, if you will.

hospital that worked for him would do it.

Q Did you write to Mr. O'Connor expressing the gratitude that you were not forced to take drugs due to your Christian Science study?

A Did I write him about that?

Q Yes, sir.

A No, sir, there was no occasion to write him about it.

Q If you would turn to page 186, to the report in front of you.

A 186?

Q Yes, sir, to see if that record refreshes your memory. I believe 186 would have to be the first records. There is so much that happened that I cannot recall all of the letters.

A I wrote that. That is an honest statement. Do you want me to read it?

Q No, sir. I just want to get you to confirm it. Did you receive a letter from Travelers Aid telling you that they could no longer handle you and the doctors could best help you?

A Yes, sir.

Q If you would, turn to page 312 of the record, sir, wherein you wrote to Dr. Rogers. Do you recall that letter? I think we paper clipped everything. 315

TESTIMONY OF KENNETH DONALDSON--ReCross Examination

Q August 9, 1965?

A Yes.

Q Now, are you aware that Mr. Davis had actually examined Mr. Donaldson over a year before the date he finally wrote the letter, that is, --

A Do you mean Dr. Calhoun?

Q Dr. Calhoun had actually examined Mr. Donaldson

[371]

over a year and a half before he wrote that letter, that is, say, in February of 1964? Are you aware of that?

A No, I wasn't aware of that.

Q But he didn't send in any report at that time that you are aware of?

A Not that I am aware of, no.

Q Now, you testified that Mr. Donaldson's mental condition did not change very much during the time he was in Florida State Hospital, is that correct?

A Yes, the changes that were noted are recorded in my report.

Q Is there something called the MMPI?

A Yes, sir.

Q Is there a test called the MMPI?

A Yes, sir.

Q Did you give that to Mr. Donaldson in approximately 1958?

A I believe so.

Q Did you give it to him very shortly before he was discharged?

A I believe so.

Q And is there any significant variation in the test scores?

A I don't think so.

Q So Mr. Donaldson was basically, his mental

[372]

condition was basically the same man the day he was discharged as he was in 1958, is that fair to say?

A On the basis of that test.

Q All right, now, let me ask you this. You were reading from some book which indicated that it is not at all uncommon for a person diagnosed as being paranoid schizophrenic to be quite intelligent, that is true, but that is not the same thing as saying, is it, that if you are an intelligent person you are more likely

to be schizophrenic than if you are a stupid person, is it?

A I want to be sure I get this right.

Q Let's just put it this way. If you happen to be an intelligent person is there going to be a greater risk you are going to turn out to be schizophrenic?

A No.

MR. ENNIS:

I have no further questions.

THE COURT:

You can step down, sir. Is there any further need of this witness?

MR. ENNIS:

No, Your Honor. He is excused.

THE COURT:

You are excused, sir.

MR. ENNIS:

[373]

Thank you, Mr. Davis.

(Witness excused.)

THE COURT:

the paranoid reaction category, specifically, paranoid state, not paranoid schizophrenic.

I don't see any evidence from any of the case material or test material that I have read that he is paranoid schizophrenic, and I would not in any analyzing any of the test results that I have seen here, I would never be inclined to put a diagnosis of paranoid schizophrenic on this patient.

I don't see either blind interpretation of the test which I did, or blind interpretation putting together with all of the case information which was voluminous in this case, I simply cannot see anything to indicate that he is the furthest end of the continuing paranoid schizophrenic, therefore, I would say paranoid state.

Q Dr., how much testing was done on Mr. Donaldson?

A In the hospital he was first tested a little less than two years after he came into the hospital, and he was given test batteries. That was in 1958. He was given one, two, three, four, five, six, seven, eight test batteries or eight testing periods during the hospitalization.

[393]

He was seen by the psychologist more

than that, but on some occasions he was not tested. He declined to test, to be tested on some occasions, but generally conversed with the psychologist, so that was written up, but no tests were given.

Then in addition to that eight, we have Dr. Calhoun's evaluation which took place about midway in this stream of tests. It would be -- it is the fifth of the times that he was tested, and he was tested a total of eight times, so that includes Dr. Calhoun's test.

Q When was the latest?

A The latest testing appears to have been the last report in 1970. I am sorry, 1971. Let me correct this.

The summarization here does not include the final test which took place in 1971, so that would make it nine. It is eight without Dr. Calhoun's evaluation.

Q Dr., over this period of time did the personality profile of Mr. Donaldson change in any significant degree from the first test to the last test?

A No, I would say by and large the test results were very much the same over that period of time. Specifically, the one that you can most point to as a sort of an objective measure, the MMPI looks almost the same fourteen years later as it did previously.

Q Dr., when an MMPI is done the figures

are

[394]

taken in graft, are they not?

A That is right.

Q And a graft remains or is charted out?

A Right.

Q Do each of those grafts appear to be the same?

A Very close. The primary graft characteristics are the same in 1958 and in 1971. The interpretation would be equivalent in those two cases, I would say.

Q Would you expect that graft to change from someone who had been committed against his will over a fifteen year period?

A I am not sure I can answer that. It would just depend. I would expect some people to deteriorate very markedly over that period of time and to show a much deteriorated response.

Q The fact that Mr. Donaldson did not deteriorate, does that say anything for him psychologically?

A In the sense that paranoid schizophrenia

is likely to be associated with a progressive deterioration with age, I would say that that would slightly tend you away from a diagnosis of paranoid schizophrenia.

Q Dr., can we turn to the diagnosis of dangerous to himself or to others for a moment.

Do you find anything in that record that would lead you to conclude, all of the testing, all of the data

[395]

that you have before you, that Mr. Donaldson was at anytime dangerous to himself or to others?

MR. MAHORNER:

Before you answer, I respectfully request that that record be defined so as to change that you are not referring to the hospital record, but the psychological record if that is the case.

MR. DEAN:

Refer to the hospital records also.

MR. MAHORNER:

He has seen the hospital record.

THE COURT:

Are you asking about the hospital record only, the testing?

MR. DEAN:

All of his reports and all of the testing and all of the hospital records and everything he has read.

Have you seen anything in those records that would lead you to any conclusion or to a conclusion that he was dangerous to himself or to others at any period?

A I would say the overwhelming impression of the test results and the hospital record was of non-violent behavior and non-probability of any kind of acting out behavior, and I saw no evidence that he actually had acted out in any way, and I see no clear indication from the tests

[396]

that would indicate that he would have been predicted to. In fact, he didn't.

Q Well, what is the best measure of dangerous, Dr.?

A The behvior of the patient.

Q Dr., I believe from the date you examined in Exhibit No., Plaintiff's Exhibit No. 11, which is the date supplied you from Dr. Calhoun, what three tests were given by Dr. Calhoun to Mr.

Donaldson?

A Dr. Calhoun gave first an interview of approximately an hour and a half, and then in the remaining time, about one hour, administered a brief version of the Draw a Person Test, the Thematic Apperception Test and the Rorschach.

Q Would you explain those three tests to the Jury?

A All right. The Thematic Apperception Test consists of a series of pictures about this size. Each one of the pictures is sufficiently vague so that different people might come to different conclusions as to what is going on in the picture.

The pictures are drawn somewhat sketchedly so that two different people looking at it might conclude that the person was in one case doing one thing and in another case doing another thing.

[397]

There is a whole long series and ordinarily we draw out a sample of those pictures that seem to be most likely to be relevant to this patient's problems.

The Draw a Person Test simply requires that the individual draw a person. He is first told to draw a person and when he finishes that he says, now, draw a person of the other sex, so that whichever

one he drew before, he draws in the opposite sex.

Then ordinarily a lengthy inquiry is given on this picture to ask, you know, what kind of person is this, what would you imagine this person does, what would he do in various circumstances.

This inquiry was not done in this case. There is no indication that an inquiry was given and I don't believe that it was done.

The Rorschach, again, is a series of plates, roughly this size, a little bit smaller, that are the familiar ink blot. They are what would happen if we dropped a blob of ink on here, folded it over and then turned it back, so it is an abstract design, but by looking closely at it just as if you look closely at the clouds or trees, you can see things that sort of resembles and looks like and the patient is asked in each case to tell what the card reminds him of, makes him think of, what it looks like to him.

You record his responses and then after you

[398]

have done that you go through and find out in detail on each one why he saw that particular thing and then there is a rather elaborate scoring system so that then you add up the scores and rate

him with respect to certain characteristics.

Now, again, on this rather brief testing, the testing period I gather was something in the vicinity of an hour to an hour an a half, which is about the time that is often given for one of the tests, so he did abbreviated testing in all three times because of the limited time.

He did not do an inquiry as I can tell on the Rorschach and he did not score on the Rorschach. He scored a few of the responses, but he did not score to have it tabulate.

Q Dr., in layman's language, would you tell the Jury the validity and the reliability of these three tests that Dr. Calhoun gave, say, in comparison to the MMPI?

A Well, in my opinion it is difficult to evaluate either the validity or the reliability of the Rorschach because each individual who administers it tends to question the patient differently, tends to assign scores somewhat differently, so that if you take the same record administered by one person and give it to five psychologists, the scores are very likely to be the same for all of the psychologists scoring.

There would be some general agreement as to

the kind of scores, but this means there is an unreliability in the scoring of the MMPI as far as the validity of the test, in my opinion the belief in the validity of the test.

Q Dr., may I interrupt you. I believe you said reliability. Unreliability in the MMPI, and you were talking about the Rorschach, were you not?

A Yes.

Q The unreliability is in Rorschach?

A Yes.

Q Okay.

A Thank you. In the Rorschach, no two people are likely to agree precisely point for point on the scoring, so you have an unreliability built in right at the very beginning on the Rorschach.

Simularly, on the TAT, bearly can you score that at all. On all three of these tests it is difficult to evaluate reliability because there is no systematic scoring system for two of the tests and only a general scoring system for the other one, so you have to consider it in terms of scoring unreliable.

In terms of the validity, it depends entirely on the sort of clinical skill of the interpreter. There is no

statistical reliability to the test. The research literature in recent years has been increasingly critical of the Rorschach as a usable test. Some of the recent reviews

[400]

have recommended that the Rorschach be discontinued as a clinical instrument and many universities have ceased to teach courses in Rorschach at all.

Those that continue to or some of those that continue to teach courses in it do so primarily because some of the job placements require that the person know how to do the Rorschach, and some of the expectations for licensing laws still retain that, but I would say in general it is considered sort of an outmoded instrument by those people who are research oriented and who are keeping up with research.

Q Does the same thing apply to the other two tests, Dr., generally?

A Yes, the TAT and the Rorschach and the Draw a Person.

Q Dr., which psychological tests are least reliable in predicting violence or proneness for violence?

A I don't have any figures on that. I would say that most psychological tests are not very good at predicting proneness

to violence. When you are trying to predict behavior of that sort, the actual behavior of the person is so overwhelmingly important in comparison with test results that I would say observation would be your critical issue.

Q Dr., assuming that you had received a call

[401]

and accepted employment to do psychological testing on someone in a mental hospital who was seeking his release from the hospital, what in your opinion would you do and what would be professionally proper, which test should be given?

A I would certainly include at least one objective personality test if I did also administer the projective test, which I might very well do, but I would insist on at least one objective personality test.

My own preference is the MMPI. There are other objective personality tests, but I would insist on at least the MMPI results or some equivalent of some other objective type tests to get a positive scoring.

I think I would, assuming the situation permitted it, I would want a long enough time available to administer all of the tests that I administered fully from beginning to end, and I would certainly

score and interpret the tests and prepare a report that gave the conclusions on it. I would assume that would be expected.

Q Dr., in your opinion and from your examination of these records that we spoke of, would you have ever recommended hospitalization for Mr. Donaldson?

A Let me -- are you talking about all of the records from the hospital and all?

Q Let's say in 1957 and not Marcy State.

A On the basis of the test results I doubt it.

[402]

On the basis of the description that came from the Pinellas County, I would certainly want to do a follow up and find out the accuracy of those statements. I would be inclined to not consider this person hospitalizable in general on the basis of certain psychological tests.

Q Have you ever considered -- have you ever committed anyone or recommended anyone with this personality profile?

A No.

Q Dr., do any of these tests relate to his ability to organize his thought, his conduct?

A Well, he did have some intelligence

tests which measure his intellectual functioning and whether he can organize his thinking to that extent, the TAT requires him to respond to a pretty unstructured stimulus and to develop a story sort of from beginning to end and as quickly, if somebody has disorganized thinking process because the story has no logical beginning, no logical end, so I would say those tests clearly indicate the organization of behavior.

Q And what was his organization of behavior from those tests?

A Quite well organized.

Q Dr., have you tested many college students?

A Oh, yes.

Q Approximately how many?

[403]

A Directly, probably several hundred. Indirectly through supervision of my students, several thousand, I suppose.

Q Are you familiar with their profiles on the MMPI testing?

A Yes.

Q Would you compare for the Jury, please, Mr. Donaldson with a college student, average college student, average profile?

A Well, Mr. Donaldson's MMPI profile is considerably more deviant than the average college student, although a sizable number of college students would have profiles as deviant or more deviant than he. If you push to a percentage, I would say at least 10 percent and probably more.

Q You have testified concerning Dr. Calhoun. You testified that he spent, I believe, an hour and a half with Mr. Donaldson and he spent approximately an hour in testing Mr. Donaldson, is that correct, sir?

A I believe that is correct, approximately that.

Q I would like for you to assume, if you would, Dr. Calhoun also spent one and half minutes with the staff, and I would also like for you to assume that he did not read the hospital record and from that I would like for you to professionally critique his examination of Mr. Donaldson,

[404]

if you would.

MR. MAHORNER:

Your Honor, if it please, I would like that word, that question reworded. The witness is not in a position to critique the examination. What he is critiquing is the records made of the examination.

Erie, Pennsylvania. Let's move along to the substance of this case.

BY MR. DUBOSE:

Q Now, could you read to me the opinion of Dr. Ojeda?

A Yes, sir. "I agree with the examiner." In other words, he agreed that the patient should remain in the

[443]

hospital. "I am of the opinion that efforts should be made in order to treat this patient with some intensive treatment and medication."

Q Did you treat that patient with some intensive treatment and medication?

A Mr. Donaldson at all times and all interviews refused medication.

Q How about intensive treatment?

A Sir?

Q How about --

A Intensive treatment means medication.

Q It says intensive treatment.

A Intensive treatment includes medication and electroconvulsive treatments. Dr. Adair who was his doctor at receiving

service received permission for electroconvulsive treatments, but he did not receive any because he thought he did not require any.

The only medication we could give him was either oral medication like Phenothiazine, like Thorazine or Mellaril or other type medication or give him an I. M. medication.

Q Could you explain the term I. M.?

A I. M. medication means intermuscular medication, giving it by needle, by injections, and if --

Q That was what the doctor meant by intensive

[444]

treatment?

A That is correct.

Q He meant no --

A Either that or electroconvulsive treatments, one or the two.

Q Those were the only two things he meant?

A Including occupational therapy, music therapy, religious therapy and all of the others.

Q We will get into that. Could you turn to the staff of 1964?

A Yes, sir. That is on page -- I have it page 32.

Q Page 32, yes, sir.

A Yes, sir.

Q What is the date of that staff?

A January 9, 1964.

Q Why was that staff held?

A It could be that another letter was written by Mr. Donaldson or we just brought him up for evaluation.

Q Could you turn to pages 504, 505 and 506?

A Yes, sir. I have 504.

Q Do you see that letter?

A From Mr. Stallings who was a State Representative from Duval County at that time.

Q And he was interested in Mr. Donaldson's case?

[445]

A Mr. Stallings at that particular time was interested in his case.

Q He made a visit to the hospital and --

A He sure did.

Q At the end of December?

A Sir?

Q At the end of December?

A Yes, sir, he came to the hospital to visit Mr. Donaldson.

Q About a week before Mr. Donaldson went to staff, would you say that?

A If you want to place it that way, yes, sir.

Q So it is quite probable, then, that Mr. Stallings influence brought about this second staff?

A If it is in your opinion that you think that Mr. -- he asked for the patient to go.

Q He asked?

A He did.

Q And you --

A I remember once we did, yes, sir. It could have been that.

Q Did Mr. Donaldson ever ask to go to staff himself?

A Mr. Donaldson didn't have to go to staff. He could have been released from ths hospital if he was not

[446]

mentally sick by discharge. He could have got an out of state discharge.

Q And that didn't require going to staff?

A No, sir. Sometimes it doesn't require it. It was up to the superintendent's pleasure, the superintendent and the clinical director.

Q Could you turn to No's. 526 and 527?

A 526, yes, sir.

Q Is that a letter or a carbon of a letter from Dr. O'Connor to Representative Stallings?

A Yes.

Q And does that report the results of the staff of January 9?

A It reports -- what was your last question, sir?

Q Is that a report to Representative Stallings of the staff conference held on that day?

A On 524, here it says, it gives the

date that Mr. Donaldson will come to the hospital.

Q 526 and 527, excuse me.

A 526, all right, 526, yes, sir.

Q So Dr. O'Connor certainly felt that Representative Stallings wanted an immediate report on the staff?

A If you want to take it that way, yes, sir.

Q Now, let's turn back to the staff, itself.

[447]

A In 1964?

Q In 1964.

A That is 34, isn't it?

Q Turn to page 33, the last doctor.

A 33?

Q Yes.

A Just a minute. 33.

Q Yes, would you read the quotation from Dr. O'Connor?

A "Dr. O'Connor: No question about me agreeing. The consensus of opinion is

to hold him in the hospital; that he is incompetent and considered to be dangerous to others; and that he should be held in the hospital until further improvement."

Q Now, at that staff conference none of the other doctors are recorded as having said Mr. Donaldson was dangerous, are they?

A No, it is not here. They felt that he was paranoid and incompetent, so even if he is paranoid and incompetent, he still stays in the hospital, even with those two characterizations.

Q Okay, but I am interested in Dr. O'Connor's characterization of dangerous. Do you --

A That was his personal opinion.

Q Was there any evidence at the staff, presented

[448]

to the staff meeting in your recollection that would have given a foundation for that conclusion?

A I don't remember if this was the particular time Mr. Donaldson and Dr. Dunin had a run-in together in 1964, but, and this is the thing that may -- I think they both were banging the table, so it could have been from that.

Q Do you remember the name John Lembcke?

A Yes, sir.

Q Who is John Lembcke?

[455]

A John Lembcke was an accountant from New York, Binghamton, New York, or Utica, New York, with whom Mr. Donaldson corresponded and was trying to discharge him in his care.

Q Would you turn to 540, please?

A 540, yes, sir.

Q Now, is this a request for Mr. Lembcke to have Mr. Donaldson released in his care?

A Yes, sir.

Q Now, when you received that letter was there a note attached onto it? I believe it is No. 538.

A When I received this letter?

Q Yes.

A Or just this little clipping here?

Q Right, and is that note in Dr. O'Connor's handwriting?

A Yes, this is in O'Connor's handwriting.

Q Could you read it? I am going to pass it among the Jury, but handwriting is sometimes difficult to people who aren't familiar with it.

A Oh, what Dr. O'Connor said, yes, let me see. I guess he is referring to Mr. Lembcke and I remember about this. This man --

Q Just read from the beginning.

A The note is addressed from Dr. O'Connor to

[456]

Dr. Gumanis, and he says, "This man, himself, must not be well to want to get involved with someone like this patient, who even the recent visiting psychological considered dangerous."

Q Did you dictate this letter? It is No. 541.

A Yes, my initials are on there. I dictated it.

Q Could you just explain to the Jury the significance of the initials below?

A The initials?

Q Below the signature block.

A Well, the letters were signed by the clinical director.

Q Right.

A But the letter was composed by the physician.

Q And those, the initials J. G. below mean that you dictated the letter?

A Right.

Q Now, did you dictate that letter in response to Dr. O'Connor's note?

A Sir?

Q Did you dictate that letter in response to Dr. O'Connor's note?

A No. As to the condition of Mr. Donaldson, I thought the man was still sick at this time, because this is July of 1964 and he had recently gone to staff.

[457]

Q Let's turn back to Dr. O'Connor's note.

A Yes, sir.

Q I don't think you read this small section down there in the lower left hand corner. Would you please read that?

A "Recommend --" I don't --

Q What does it say?

A "Recommend turn it down."

Q "Recommend turn it down", so it was --

A Dr. O'Connor was the one that was going to sign the release if this patient was discharged.

Q So it was his recommendation not to release Mr. Donaldson to Mr. Lembcke?

A I gave Mr. Lembcke a resume of the patient's mental condition and then I later on put in the wishes of Dr. O'Connor, that the, and we gave him the -- we gave him the condition how he was, a picture of his condition.

Q Now, did you speak --

A Because, excuse me, because if this patient was released to Mr. Lembcke in New York, in Binghamton, New York, Dr. O'Connor was the one that would sign the discharge.

Q So that --

A With the Clinical Director together.

Q So that Dr. O'Connor was the one who, if he disapproved of it, you might as well forget about it, is that

[458]

right?

A That is correct. That is what it comes down to, to any superintendent of any hospital, and it is the same in any state.

Q Did you speak to the Plaintiff before you wrote the letter to Mr. Lembcke?

A I think I did. I don't recall offhand. I probably did. When did he go to staff in 1964?

Q He went to staff a good deal before that, I believe, in January of 1964.

A Because I knew Mr. Donaldson's. January of 1964, that is correct, but I interviewed him later on, too.

Q What did you know about Mr. Lembcke at the time you wrote that letter?

A What did I know about Mr. Lembcke? He just asked for some information about the patient.

Q Didn't he ask to have the patient released in his care?

A Yes, sir.

Q And you sent him a letter rejecting that request, did you not?

A Well, if the superintendent told us that he will not sign any papers discharging him, I could not do anything else. I could --

Q Do you know if --

[459]

A I could not discharge him.

Q Do you know if Dr. O'Connor knew anything about Mr. Lembcke?

A I wouldn't know. I don't think so, because Mr. Lembcke, I think, didn't come down to Tallahassee until 1966.

Q So he had never been down here, nobody at the hospital had ever seen him, right?

A Yes, sir.

Q Now, did you think that Mr. Lembcke, and I will pull the note, must not be well to want to get involved with the Plaintiff?

A No, I cannot say that.

Q In your interrogatory -- never mind. Now, did you communicate to Dr. O'Connor that you didn't agree with him?

A I didn't say that I didn't agree with him. I thought the patient was still mentally sick.

Q Oh, you did? Well, I am talking about Mr. Lembcke.

A Oh, no, I didn't say anything. That was his personal opinion. I didn't discuss that.

Q You didn't agree with that?

A I didn't discuss that.

Q The question --

[460]

A How could I agree when I didn't know Mr. Lembcke at that time?

Q Did you tell Dr. O'Connor that?

A I didn't tell him anything. He probably sent me this note.

Q Was he the kind of a man that you couldn't tell things to?

A Oh, yes, we talked with Dr. O'Connor, could talk to him.

Q But you went along with his decision that Mr. Lembcke was not --

A You have to go with the decision of the superintendent most of the time.

MR. MAHORNER:

Your Honor, we object to the statement as being unfair because the decision was to keep the man in the hospital. The reasons for it may vary, but when he states a question this way, he went along with his decision, and then ties it in to that note, it is unfair to the witness.

THE COURT:

Well, the question was, as I understand it, did you agree with Dr. O'Connor that Mr. Lembcke was not a proper person for this man to be released.

THE WITNESS:

We only had seven --

[461]

THE COURT:

Well, wasn't that the intent of your question?

BY MR. DUBOSE:

Q Yes, sir.

A There was only seven lines in this letter. I couldn't form an opinion of what Mr. Lembcke was except that he was a certified public accountant. That is all I know about him.

THE COURT:

Did you or did you not agree with Dr. O'Connor?

THE WITNESS:

I had to agree with Dr. O'Connor.

THE COURT:

years and I don't see it in here.

Q Is there any indication in the record that you can see that such an investigation was ordered?

A If it was it was not in here or in my notes. That was in July of 1964.

Q I believe your letter was dated July 2, 1964.

A Sir?

Q I believe your letter was dated July 7, 1964.

A The only thing I have in here on July 7, 1964, is that Mr. Donaldson resides on ward, shows no particular changes mentally. He is still delusional and his judgement

[466]

is poor. States he will live in Syracuse, New York, and receives Social Security of $100.00, $101.00, and Mr. Lembcke, a public accountant, wishes to sponsor him in New York. However, Dr. O'Connor does not agree with this man. That is all I wrote.

Q Would you turn to 553, please?

A Sir?

Q Page 553 in the record.

A Yes, sir.

Q Have you seen that letter before?

A I presume I have. This is the first time I have seen it. I have seen a lot of correspondence of Mr. Lembcke.

Q When you received that was No. 554 attached to it? That is the small card stapled to the front.

A Well, as I said before, Dr. O'Connor was the one that should release this patient and he gave us directions as to what to do.

Q But this note was attached to it when you got it?

A Yes.

Q Again, would you read the note to the Jury, please?

A The note, I believe must have parents consent, number one. Dr. Gumanis, I believe must have parents consent.

[467]

Number two, patient will not stay with party mentioned. Number three, we don't know anything about party, etc. O'Connor, please answer in negative.

Q And in response to that note, did you write No. 555?

A I sure did.

Q Dr. O'Connor gave a number of reasons this time why he was turning down Mr. Lembcke, didn't he?

A I gave -- he might have given that reason, but I had my reasons, too. I thought Mr. Donaldson was ill.

Q You wouldn't have released him, either?

A I wouldn't have released him, either, no, except if they made special arrangements like have the patient follow up with psychiatric care and everything else.

Q Any other special arrangements that you would have required?

A Just about that.

Q Why didn't you mention them in your letter to Mr. Lembcke?

A Sir?

Q Why didn't you mention those requirements to Mr. Lembcke?

A I listed the requirements that Dr. O'Connor had in his note, because he was the one that was to release the patient.

[468]

Q Why didn't you mention his requirements

to Mr. Lembcke?

A He told me to put it in a negative manner and that is exactly what I done.

Q If Dr. O'Connor said no, you didn't think it was worthwhile letting Mr. Lembcke know what his reasons were because Dr. O'Connor's no was a solid, firm no?

A I couldn't do anything because I could not release the patient. Dr. -- as I said before, Dr. O'Connor was the one that had to sign his release with the Clinical Director. They were the two that were responsible for release to another state.

Q Is there any indication in the record that Dr. O'Connor made any effort to find out anything about Mr. Lembcke or to communicate with him the reasons why he thought Mr. Lembcke would be an unsatisfactory patron of Mr. Donaldson?

A I don't recall them.

Q Just take a look at the progress notes if you want and see if you can find anything.

A Do you mean my progress notes?

Q Yes.

A I don't recall any. I don't see anything in here.

Q But didn't Mr. Lembcke, in his letter, say

[469]

that he would be willing to give any information that the hospital desired?

A Well, if Dr. O'Connor wanted a negative answer, we couldn't go ahead and investigate Mr. Lembcke, as you say.

Q Now, did Mr. Lembcke ever visit the Florida State Hospital?

A I think he visited the Florida State Hospital during 1966.

Q And did you meet him during that visit?

A He came down to my office, I remember, I think. I recall it.

Q What was your opinion of Mr. Lembcke?

A He looked all right to me.

Q After you took Mr. Lembcke, where did he go.

A I escorted him over to Dr. O'Connor's office.

Q and Dr. --

A As far as I could recollect, now. I don't remember, but I think I did, because I could not give Mr. Lembcke an answer.

Q Excuse me. I didn't hear your answer.

A I could not give him an answer as to

the release. I talked to him about the patient's condition, what we thought about it, but I couldn't give him an answer as to release plans. He had to see Dr. O'Connor.

Q But as far as you could tell, Mr. Lembcke

[470]

would have been adequate to manage Mr. Donaldson?

A As far as I could tell. I didn't see anything wrong with Mr. Lembcke. He talked all right to me.

Q Was there anything that Florida State Hospital provided for Mr. Donaldson that Mr. Lembcke couldn't have provided?

A I don't know what Mr. Lembcke could provide for the patient.

Q Well, what did the Florida State Hospital provide?

A Well, we tried to give the patient medication. He refused that on the basis of his religious belief.

Q So that wasn't something you provided?

A No, it was not.

Q What else did you provide for Mr. Donaldson?

A We tried to make him as comfortable as we could.

Q Could Mr. Lembcke have done that?

A It could be.

Q Anything else?

A Well, he had, shall we say, milieu therapy which included religious therapy, recreational therapy. He didn't receive much occupational therapy in our department, and other forms.

Q Let's go through those things. Religious

[471]

therapy. He could have gone to a church?

A Yes.

Q With Mr. Lembcke, couldn't he?

A Right.

Q And he could have gotten a job, couldn't he?

A Could the patient have had a job?

Q I mean he could have gotten a job when he was living with Mr. Lembcke?

A It is possible, yes, sir.

Q So that was about the same thing as occupational therapy, right?

A Is that about the same thing as occupational therapy?

Q Occupational therapy, wouldn't it serve the same purposes?

A Well, I would say so, yes, sir.

Q And he could have amused himself any way he wanted, could he not, and that would be about the same as recreational therapy, wouldn't it?

A Yes.

Q So really there was nothing that Mr. Donaldson received at Florida State Hospital that Mr. Lembcke couldn't have given him, isn't that true?

A Well, I don't know if Mr. Lembcke could have provided him with supervision that the patient had at

[472]

Florida State Hospital.

Q What kind of supervision did he have?

A He wasn't free to go out and express his various delusions.

Q Oh, Mr. Lembcke probably couldn't have kept him locked up, is that right?

TRANSCRIPT OF TESTIMONY

11/27/72

PROCEEDINGS

November 27, 1972

[4]

THE COURT:

Good morning. Be seated, please.

Would Counsel approach the bench, please.

(Whereupon, the Attorneys approached the bench.)

MR. DUBOSE:

We are continuing with the testimony of John Gumanis, please.

WHEREUPON

JOHN GUMANIS

the witness on the stand at the time of the recess, resumed to the stand and testified further:

DIRECT EXAMINATION

MR. DUBOSE:

Q The last time we were discussing the

possibility of release for Mr. Donaldson I am afraid we may have confused the Jury a bit. Could you explain to the Jury the different types of releases which were possible at the Florida State Hospital?

A There were three different releases.

First was furlough, which was signed by the attending Psychiatrist and the Superintendent.

The second release was an out of State discharge which was signed by the Physical Director and the Superintendent, and the third release was a competency discharge which was signed by various Doctors, the Superintendent and the Clinical Director.

[5]

Q Now comes the competency discharge, when someone received that, then all of their rights were restored. Is that right?

A They usually go to the Courts and have their rights restored. They could do it within thirty days, I believe.

Q That doesn't happen automatically in the other types of discharge, does it?

A No, sir.

Q In those types of discharge the patient could still be mentally ill could he not?

A Could be, yes, sir, especially on a furlough. We--may I explain something? We give the furlough because it is easier for the patients. A furlough is good for one year and the relatives could return the patient back to the hospital.

Q So you have, yourself, furloughed patients who were still mentally ill?

A I have furloughed patients, yes, sir.

Q So the fact that Mr. Donaldson was mentally ill when Mr. Lembcke wrote into the hospital to release him did not itself bar release of Mr. Donaldson, did it?

A May I get that question again, please?

Q Well, you said before that when Mr. Lembcke wrote in for Mr. Donaldson's release Mr. Donaldson was mentally ill still, but that alone wouldn't have been enough reason to bar?

A No, sir.

[6]

Q For a competency discharge you had to go before a Staff, is that correct?

A Yes, sir.

Q You didn't for the other two?

A No, sir.

Q What kind of power did you alone have to release Mr. Donaldson?

A The only power I had was to on a furlough, but on this particular case Doctor O'Connor knew the case for two and a half years and I had to ask Doctor O'Connor if this patient to even would have released on a furlough.

Q But normally you could have released him on furlough by yourself?

A Sometimes, yes, sir, on very difficult cases we consulted the Clinical Director or the Superintendent.

Q But in this particular case Doctor O'Connor had made it clear to you that he wanted to have the final say on release?

A He had not made it clear to me. We knew the specific cases, some specific cases that were complicated. We had to receive the permission either of the Clinical Director or the

Superintendent.

Other cases that were ordinary cases went home, we just went ahead and furloughed him ourselves and Doctor O'Connor also signed, the Superintendent signed the furlough papers.

Q But you know that Doctor O'Connor in this particular case would want to approve it himself?

[7]

A Well, I knew the case was complicated.

Q Now, how come the Plaintiff was eventually discharged from the hospital?

A Well, the patient was - Mr. Donaldson was transferred from my department in 1967 and I know that he was finally discharged by three doctors that saw him, Doctor Rodriguez, Doctor Pinell, who is in Texas now, and who was a Clinical Director at that time and from Doctor O'Connor, and Doctor Hirshberg.

Q And he didn't go before Staff then, did he?

A I don't know if he went before Staff but I would not know that for he was never in my department.

has personal knowledge of it, which he has already stated he didn't, discuss this letter with the Jury, but if you wish to read the letter to the Jury, read it. It is already in evidence.

[9]

MR. DUBOSE:

Q It is already in evidence. I just wanted to bring a conjunction. Now, you say that Doctor O'Connor knew of Mr. Donaldson's case?

A He knew of Mr. Donaldson's case because he was the attending Psychiatrist from December 1957 until October of 1959. He was not Assistant Clinical Director or Clinical Director or Superintendent. His position at the hospital was Staff Psychiatrist of Department "A".

Q So he was Staff Psychiatrist up until 1959 and where was he located in the department?

A Department "A."

Q That was the department that you are now on?

A Yes.

Q And you were on then?

A I was there with him, his associate, yes, sir.

Q And Doctor O'Connor was in charge of the department?

A Yes.

Q And he was also Plaintiff's attending Psychiatrist?

A That is right.

Q After that period you were the attending Psychiatrist?

A After that period I was, and about, at least five other Psychiatrists.

Q Who were the other Psychiatrists?

A The other Psychiatrists were Doctor Shaw,

[10]

Doctor Chacon, Doctor Haneson and Doctor Rodriguez.

Q Well, let us say that up until 1967 when he had left Department "A," what other Psychiatrists had contact with Mr. Donaldson?

A Doctor Shaw and Doctor Chacon.

Q But you had most of the contact?

Q How long was Doctor Shaw in Department "A?"

A I believe two or three years.

[11]

Q And Doctor Chacon?

A I mean Doctor Chacon, I didn't remember Doctor Shaw. It was about a year, I presume.

Q A very short period?

A I don't recall.

Q How come there are no progress notes from Doctor O'Connor in the record. Do you know why that is?

A Well, Doctor O'Connor usually did not make any notes. The only notes were when he had, when he interviewed the patient and when he had letters, the letters from 1957 to 1960 are all from the parents, from Kenneth, Mr. Donaldson, were all answered by Doctor O'Connor.

Q After that all the letters up until 1967 were answered by you, is that true?

A Right, yes, sir.

Q Even though Doctor Shaw and Doctor Chacon occasionally came into the

picture, they never corresponded with the outside parties?

A No, sir.

Q Now, if you could turn to the progress notes of March.

A What page is that on, please?

Q It is Page 66, March 5, 1964. That is at the bottom of the page.

A Yes, sir.

Q It states that Mr. Donaldson wanted $100.00 sent to his daughter in order to facilitate his discharge to the Half-Way House in Minnesota?

[12]

A Yes.

Q There is a parenthetical note here, after consultation with Doctor O'Connor it was decided that it would not be sent until arrangements for the patients release were made.

A Usually if a patient asks for a large amount of money over $30.00 or $40.00 it was up to the Superintendent or the Clinical Director to decide on that.

Q And why did Doctor O'Connor decide not to send money?

[13]

past, myself, without consulting Doctor O'Connor. If Mr. Donaldson wanted to go to his parents, that is either Kenneth refused, saying that he didn't want to go, or that he would tell me consult my lawyer, or in 1964 he brought Mr. Stallings into the picture.

Q Well, in April of 1964 you were willing to let him go to his parents. Why weren't you willing to let him go to Mr. Lembcke in July of 1964?

A I told you before that wasn't my decision. It was up to the Superintendent to decide if Mr. Donaldson was to be released to Mr. Lembcke. It was an out of State discharge and I could not sign anything like that. It was up to Doctor O'Connor and the Clinical Director.

Q And you had no opinions one way or the other in the matter?

A I could not do anything, no sir.

Q Now, if you will turn to Document No. 495, please.

A Yes.

Q We looked at the last time period was a letter to Helping Hands turning down their request to Mr. Donaldson?

A 495?

Q 495, yes, sir.

A Yes, sir.

Q Now, you said you wrote this and your initials are in the lower left hand corner?

A Correct.

[14]

Q Doctor O'Connor's initials are also there?

A Correct.

Q In what roll did he have in composing that letter?

A I told you the other day, I presume, in my deposition I said that I was of the opinion the patient would be helped from Helping Hands. I still think the patient could have been helped by Helping Hands.

Q So it was primarily Doctor O'Connor's opinion that Mr. Donaldson should not be released to Helping Hands?

A It was in Minnesota, so, I had nothing to do with it.

Q I am just trying to locate where the decision was made, not to send --

A The decision was made by Doctor O'Connor, the Superintendent, yes, sir.

Q O. K.

A And it was still made at the hospital, the policy for out of State discharges, or anything else, still in this State are made by the Superintendent or the Clinical Director.

Q Did you ever refuse to see Mr. Donaldson?

A I don't recall.

Q Did you ever refuse to see any patient at Florida State Hospital?

A Sometimes if we have meetings in the afternoon I would tell them to see me another time.

[15]

Q Did you ever refuse to see a patient that was brought to you on a stretcher because he wasn't on your list?

A We treat all emergencies at once.

Q Is that a yes or no, or did you ever refuse to see a patient?

A I have never refused to see a patient on a stretcher.

Q Does the name Joe Lewis Simmons recall any particular incident to your mind?

A Simmons?

Q Simmons, Joe Lewis Simmons?

A No, sir, but I remember the name, but I don't recall the patient.

Q And you do not recall refusing to see him when he was brought to you on a stretcher?

A I do not recall it, no sir.

MR. MAHORNER:

Your Honor , the question was worded as a statement that the man was brought and I object on that basis.

THE COURT:

The objection is over-ruled.

MR. DUBOSE:

Q Now, we have been talking about release to Mr. Donaldson's parents, and the release that required the consent of his parents?

A Yes, sir.

Q And we discussed the age of his parents.

[16]

Would you open to Document No. 496?

A Yes, sir.

Q That is a letter from Mr. Donaldson's parents, is it not?

A Yes.

Q And you answered that letter, didn't you?

A I did.

Q Doesn't the letter state that Mr. Donaldson's age, that is, the Senior Mr. Donaldson's age was 85?

A Yes, sir.

Q And you received this letter the day after you wrote to Helping Hands, didn't you, saying that he would only be released to his parents?

A In Helping Hands, this letter was written at this time, yes, sir.

Q Right. Now, when you wrote back to his parents on July 25 or June 25, why didn't you mention that Helping Hands had requested to have Mr. Donaldson

released?

A There is correspondence here that I could not--there is a correspondence further down--that there was correspondence going between the Superintendent. There is a letter to Doctor Stallings, Mr. Stallings, in Jacksonville, here. At the same time in 1963 there was correspondence being carried by the Superintendent and a Helping Hands to have the patient released.

Q I am asking you why on June 25 you didn't tell the parents that this was being done if parental permission was going to eventually be required?

[17]

A I don't think it was my position to do that. The permission, if it was to be requested in the final decision, on that would have been the Superintendent.

Q You didn't think it was worth mentioning to the parents?

A I thought that it could have been worth mentioning, yes, sir, but I was not the one to make the decision on it.

Q But the parents would have to make a decision about releasing Mr. Donaldson, wouldn't they?

A I presume he did.

Q That showed he was pretty competent, didn't it?

A He was pretty --

Q Competent. He could do things with his hands?

A Well, manual things, I presume he could have.

Q So he probably could have earned a living if he had gone out of the hospital?

A I guess so, yes, sir.

[38]

Q What is custodial care?

A Custodial care is when the patient mostly does not receive medication and he receives other types and forms of therapy, but usually it is not when he does not receive any treatment at all.

Q Now, will custodial care help a paranoid schizophrenic?

A Sir?

Q Will custodial care help a paranoid schizophrenic?

A No, sir. Paranoid schizophrenics require medication.

Q Then why --

A And other forms of therapy.

Q Then why did you order that Mr. Donaldson in a number of progress notes you say continue custodial care?

A Out of the 53 notes it is written in there into the chart, custodial care is mentioned into the first note because, and I put that in there because the patient was not receiving any medication at that time. He refused medication and the other two times I usually place this custodial care is because of the patient refused medication.

Q Well, all I wanted to know is why did you order custodial care if you knew it wouldn't do any good?

THE COURT:

[39]

He just got through telling you twice.

How many times are you going to ask him the question? Move on.

MR. DUBOSE:

Q What therapy did Mr. Donaldson receive?

A Mr. Donaldson, because he refused his medication and he also refused a few times individual and group therapy, his treatment was mostly milieu therapy which included recreational therapy, religious therapy, music therapy and other activities that the hospital could provide.

Q What does recreational therapy consist of?

A Dancing, playing instruments.

Q Hobbies?

A Sir?

Q Hobbies, amusements, a movie occasionally?

A A movie, yes, sir.

Q What did musical therapy consist of?

A Well, they went to the dances and I think some of the patients were occupied in learning how to play instruments or play with the band. They had their own band.

Q What did religious therapy consist of?

A Activities in church and the pastor and the preacher visited them at the hospital.

Q In other words, the therapy he received was to be able to go to movies, to be able to go to dances and to be

[40]

able to go to church?

A That is what the hospital records --

Q He could have received those on the outside, couldn't he?

A He could but he could also receive other forms of therapy on the outside, too.

Q To turn back to these progress notes for a moment, weren't most of these progress notes, which record contact you have with the plaintiff, weren't most of those of an administrative nature?

A No, sir.

Q Then most of them were of a therapeutic nature?

A Therapeutic and diagnostic nature.

Q I turn to your deposition, page 51, lines five through eight.

A He escaped. They had him in the agricultural department as far as I can remember and he escaped from them and then he returned back and then he was assigned to the dining room area, I believe.

Q But did he after that work on the ward, itself? He was on a closed ward, was he not?

A He did at times, Kenneth helped elderly patients, yes, sir.

Q And I think at one point stopped doing any work on the wards?

A As far as I could recall, he did.

Q And did you talk to him about that?

A No, sir, but I don't recall.

Q Well, wouldn't that have been an important point to talk to him? Didn't the fact that he had stopped working

[42]

signify that he was giving up?

A We usually do not try to force the patients to work that I know it would have been of therapeutic value to him if he continued working, but on the other hand, we do not try to force

the patients to work.

Q But you didn't talk to him to find out why he had quit?

A No, sir, I did not talk to him but I don't recall talking to him but I don't recall.

Q Now, while Mr. Donaldson was in Department A he never had grounds privileges, did he?

A Correct.

Q Why not?

A He didn't have the grounds privileges because I consulted the superintendent and he advised me not to give any and there was a history that he ran away once.

Q Now, in the progress note --

A What page is that on?

Q 11/62.

A What page?

Q The very bottom of page 65. It says asked for privilege grounds and request denied.

A Correct that I consulted Doctor O'Connor and we decided not to give him one.

Q Why did you decide not to give him one?

[43]

A Let me read my notes first. That note is on the bottom of the page.

Q The very bottom of page 65?

A Oh, 65? Is that 1962? What is the date on the note?

Q That is the very bottom, 7/11/62.

A 7/11/62?

Q Let me read it to you in its entirety if you cannot find it. Patient states that other patients called him a homo and called his family bad names, asked for privilege care, request denied.

A Yes.

Q Why did you deny that card?

A I thought that Mr. Donaldson at that particular time in 1962 Mr. Donaldson, between 1962 and 1963, was really upset.

Q He was really upset?

A Yes, sir.

Q And it was necessary to keep him on a locked ward?

A That is correct.

Q And this was a decision you reached on your own without consulting Doctor O'Connor?

A I probably did, yes, sir.

Q And you thought this was of therapeutic value?

[44]

A It wasn't a matter of therapeutic value, but it was a matter that the patient was delusional at that particular time. He wrote numerous letters at that particular time to various persons expressing that he was poisoned, chemicals were placed in his body and other --

Q And because he wrote the letter he had to stay on the ward?

A Psychotic patients do stay on the ward, yes, sir, but we try to keep them on until a remission is produced to release him or put to them on the outside.

Q While Mr. Donaldson was on the ward, did you ever observe him to be in any way physically dangerous, violent, agressive?

A No, sir.

Q So he wasn't a dangerous person?

A I wouldn't say he was dangerous. I cannot say what he would have done on theoutside but while he was in the hospital he never showed any homicidal tendencies.

Q And is there anything into the hospital record that indicated on the outside that he was --

A Well, the commitment papers state that the patient was potentially dangerous, if I am not mistaken, because of his delusions.

Q But that is the only evidence that you have?

A As far as I could remember.

[45]

MR. DUBOSE:

May I have a moment, Your Honor?

THE COURT:

Yes, sir.

MR. DUBOSE:

Now, what good did you think further hospitalization would do for the plaintiff?

TESTIMONY OF DR. JOHN GUMANIS--Cross Examination

[61]

Q When was the last time that you acted as attending physician to Mr. Donaldson?

A March of 1967.

Q Did you see him in a medical capacity after that as to staff or anything?

A I saw him at the staff during 1968.

Q O.K., then after 1967 was 1968 that one time in staff in 1968 the only time that you saw him in a medical capacity?

A Yes, sir.

Q Did the defendant ever refuse to go to a trial visit in your presence or decline to take a trial visit?

A He declined a few times, yes sir.

THE COURT:

Are you talking about Mr. Donaldson?

MR. MAHORNER:

Q I apologize to the Court and the jury. Mr. Donaldson.

A Mr. Donaldson refused numerous times saying he either didn't want to, he couldn't get along with his parents, or that he will consult and his lawyer and later on it was that he wanted to consult Mr. Stallings.

danger, but who needed treatment?

A Correct.

Q What is the primary method of treating a disorder

[66]

of the nature that Mr. Donaldson had suffered under?

A Well, in the past it was electro-convulsive treatments which he received at the Marcy State Hospital, but later on with the medication it was milieu therapy, medication, group therapy and psychotherapy.

Q Why wasn't Mr. Donaldson given medication?

A He wasn't given medication because during my first interview he told me that he belonged to the Christian Science group, and that he told me not to force medication on him, so I respected his religious beliefs.

Q Did Mr. Donaldson ever speak to you as to the Representative Stallings?

A Did he speak to me about Mr. Stallings?

Q Yes.

A Yes, sir, he did.

What did he state to you at any time specifically as to whether Mr. Stallings represented him as his lawyer, or do you recall?

A I think he told me once that he was his lawyer.

Q Now, as to -- it has been brought out, Mr. Donaldson has three children.

A Four.

Q Are you married?

A Yes, sir.

Q Do you have any children?

A I have two children, ages 4 and 2.

MR. MAHORNER:

I have no further questions.

REDIRECT EXAMINATION

MR. DUBOSE:

Q Just a couple short redirect questions.

When did Mr. Donaldson refuse to go on trial

[65]

visits?

A He refused to go on trial visits as he told me again he couldn't get along with his parents.

THE COURT:

The question was when.

MR. DUBOSE:

Q The question was when. When did he refuse?

A When?

Q Yes, sir.

A I think it was about 1964.

Q Did you record that in his progress notes?

A I don't recall, but I think there is a letter somewhere. I don't remember.

Q Did you communicate at all with his parents concerning the trial visits?

A No, sir. No, sir.

Q When did Mr. Donaldson refuse vocational rehabilitation?

A In 1967.

Q Did you record that in the progress notes?

A I don't recall. It is five years now, but it might be in the record, but I don't recall.

Q Would you just take a look? It is right in front of you, page 67, I believe, or page 66.

A Just a minute. The note on 1/20/67 says when

[69]

asked if he wishes to believe by receiving help from the vocational rehabilitation service, he stated that Mr. Stollings will have to be present and he will and will be with him at staff.

MR. DUBOSE:

No further questions.

THE COURT:

You can step down, sir.

(Witness excused)

THE COURT:

Proceed.

READING OF INTERROGATORIES TO DR. O'CONNOR

[82]

Set 1, number 38-A, do you have, one, personal knowledge or two, second-hand knowledge of any occasions during plaintiff's hospitalization when plaintiff committed or threatened to commit any act that was or would have been physically dangerous to himself or to others? No.

Set 2, number 8. During the period of March 30, 1957 to May 18, 1959, was plaintiff in any way a management problem? If so, explain each such instance in detail. If not, explain why plaintiff did not have grounds privileges during this period? Plaintiff did escape from the hospital once but as far as I know, plaintiff was not harming anyone else. In the opinion of plaintiff's attending physician, he apparently thought plaintiff was too delusional to make an adjustment outside of the hospital.

[84]

Set 3, number 40-A, did plaintiff ever cause injury of any sort to any person because of his delusions? I do not know. I have no recollection of such having occurred.

Set 3, number 60-A, had the plaintiff ever been arrested prior to his commitment to Florida State Hospital? I do not know. The committing judge would probably know.

Set 3, C, had plaintiff ever been convicted of any crime prior to his commitment to Florida State Hospital. I could not be certain. To my knowledge and recollection, no.

Set 3, 22-A, in a handwriten note to Doctor Gumanis dated 4/2/64, you wrote that "all paranoids can be plausible to gain a point -- but once out of hospital they resume their attacks on society and their annoyance of all authority. Did you write that note? Yes, sir.

Set 3, 22-B, state each attack on society which

[85]

plaintiff would have made if released on April 2, 1964. I could not know since he was not released. In my opinion, persons suffering from these disorders generally attack society verbally.

Set 3, 22-G, how would plaintiff have annoyed authority if he had been released on April 2, 1964? I am not able to conject it because he was not released on that date.

Set 3, 22-H, how had plaintiff annoyed authority prior to his commitment to Florida State Hospital? It was the understanding of the staff at the hospital that he had annoyed authority prior to entering the hospital for reasons given by the committing report for his entering Florida State Hospital. I do not know other than I believe the staff thought he had annoyed authority.

Set 3, 22-I, state every place in plaintiff's hospital record which records plaintiff's annoyance of authority. I cannot locate such, but people with the diagnosis assumed in this case can generally be expected to continue paranoid behavior.

Set 3, 35-D, under what circumstances would plaintiff have been released from Florida State Hospital? Whenever the staff of the hospital had reached the conclusion that he would make a successful adjustment outside the institution.

[86]

Set 3, 12-A, a letter dated May 30, 1957, that you dictated states that plaintiff would be unable to adjust well outside of an institution. Explain precisely what "unable to adjust well" meant.

Unable to make a living, unable to get along well with other people, unable to live outside an institution.

Set 3, 12-B, if plaintiff had been released from Florida State Hospital on May 30, 1957, what would have happened to him? I cannot conjecture about an event that did not happen.

Set 3, 12-C, state the evidence on which you base your answer to 10-B. Since he was not released on that date, I do not know what would have happened to him.

Set 3, 29-A, for what purpose was plaintiff retained at Florida State Hospital? He was retained until the staff of the hospital was convinced that he could make a successful adjustment outside the hospital and in hopes some day he would evidence that such would occur. He was retained in order to receive the care necessary for him to make this adjustment.

Set 3, 13-A, a letter dated May 11, 1957, which you dictated stated the plaintiff needed "further hospitalization before considering his release."

What good did you then feel that further hospitalization was due plaintiff? The staff of the hospital

[87]

hoped that the plaintiff could be persuaded to accept medication in order to determine whether this procedure would be beneficial.

Based on the information available to me the plaintiff's record as to patient's mental condition, I was concluding that he required further evaluation and treatment before it could be determined that he could function outside an institution.

Set 3, 13-F, what would have happened to plaintiff if he had been released on May 11, 1957? That was uncertain, but it was considered unfair to the patient to release him unless he was under suitable supervision.

Set 3, 13-G, state the evidence on which you concluded that plaintiff could not be released without further hospitalization. The opinion of the staff after going over the patient's case was that it would not be wise to release him at that time, and see answer to 13-A.

Set 3, 37-A, in the post-staff dictation following the conference of January 21, 1964, you are quoted as saying that plaintiff was "considered to be dangerous to others."

Is this quotation accurate? I am summing up the consensus of opinion expressed by others on the staff before me, not one of which believed that he should be released at that time. That is my statement of the staff's opinion and

[88]

that of Doctor Franklin Calhoun, the

psychologist from Jacksonville who examined the patient.

Set 3, 37-B, state the manner in which plaintiff was dangerous to others. This was the consensus of opinion of staff of the hospital who had just had the patient before staff, and I do not know the specifics that went into that conclusion.

Did you dictate a letter to Honorable George Stallings, Jr., dated January 9, 1964? Yes, sir.

That document is number 526 and 527 for the record.

Set 3, 39-C, does this letter report the opinions of a staff conference at which you were present? Yes.

Set 3, 39-D, on the second page of the letter referred to in 39-A, you wrote that the staff felt that plaintiff was "incapable of attending to his affairs outside of an institution without constant interference with others by his demands and allegations against them." On what evidence did the staff base its conclusion? I do not know how any individual other than myself arrived at conclusions, any conclusions I reached were based on the opinion of the staff an evidenced in the record.

Set 3, 39-E, what form would plaintiff's constant interference with other have taken if he had been

[89]

released on January 9, 1964? I have no

knowledge since it did not occur. It is just a matter of general opinion that a paranoid individual is one who bothers other people because he does not believe he is sick and his mission in life is to vindicate himself.

Set 3, 39-G, you also wrote in the letter referred to in 39-A that plaintiff might "present some degree of danger to others." On what evidence was this conclusion based? Opinion of the staff of the hospital. This conslusion was based on the opinion of the staff and of the psychologist from Jacksonville, Doctor Calhoun.

Set 3, 39-I, how would this danger have manifested itself? I do not know other than what the staff or Doctor Calhoun might have mentioned, which I do not now recall.

MR. DUBOSE:

I think that was incorrect. That was the answer to 39-H you read. I will repeat the question. How would this danger have manifested itself? Since it did not occur, it would be difficult to state in what particular direction plaintiff might injure himself. It was the opinion of the staff that anyone with his disorder could potentially be dangerous to others. I do not now know.

Set 3, 39-J, how likely would this danger to manifest itself if plaintiff had been released on January 9,

[90]

1964? I know of no way to evaluate such a question, and therefore, do not know as the conclusion was based on the opinion of others.

Set 2, 11-Q, the letter of June 17, 1963, this document number 495, states plaintiff's appearance were "the ones who are legally responsible for him."

Explain what legal responsibility meant. Cite all statutes that so place the legal responsibility. Patients committed to the Florida State Hospital at that time had designated on commitment papers whom the responsible relatives were.

Set 3, number 26-E, if plaintiff had been released to Helping Hands, on June 17, 1963, what would have happened? I do not know since such event did not take place.

Set 3, 26-F, would Helping Hands, Inc. have supervised plaintiff inadequately? I do not know. It was the opinion of the staff that the patient would require more supervision than would be expected of an organization. Apparently this was the opinion of the attending physician.

Set 3, 26-I, what did you know about Helping Hands, Inc. when the letter of June 17, 1963 was written? Nothing.

Set 3, 26-J, what attempts did you make to discover the professional reputation

of Helping Hands, Inc.? It was not my responsibility, therefore, none that I recall.

[91]

Set 3, 27-A, why did the letter of June 17, 1963, to Henry Cantwell state that plaintiff would only be released to his parents and not to any third party? Rules of the hospital state that patients are to be released only to their nearest relative who presumably would be willing to spend the time and money necessary to provide the patient with psychiatric care he required.

Set 3, 69-A, plaintiff's hospital record indicates that on March 3, 1964, he requested $100.00 of his funds be sent to his daughter so that she could come to the hospital and escort him to a half-way house in Minnesota. The record further indicates that after consultation with you the money was not sent. Is the money accurate? I presume the money was accurate.

Set 3, 41-A, did you write a hand-written note to Doctor Gumanis dated 7/6/64, presently in plaintiff's hospital record in which you state John H. Lembcke "must not be well to want to get involved with someone like this patient." Yes.

That is document number 538 for the record.

Set 3, 41-B, was it your opinion as of that date that Mr. Lembcke was not a man of sound judgment? This is an off-hand

remark made by one doctor to another doctor regarding a situation that had arisen calling for a decision to be made.

[92]

What I meant was that the man must not have good judgment in light of the fact that the visiting psychologist considered plaintiff to be dangerous. Mr. Lembcke had been acquainted, I presume by the staff with the condition of the patient.

Set 3, 41-D, was it your opinion as of that date that Mr. Lembcke was mentally ill? I had never met Mr. Lembcke. I had no opinion as to his own degree of sanity, but I only expressed an opinion to a doctor on the staff.

Set 3, 41-F, in the note referred to in 41-A, you recommended that Mr. Lembcke's request to have plaintiff released in his care be turned down. Why did you say recommend? Because there are some procedures that have to be gone through before any decision is made regarding any patient released from Florida State Hospital, and particularly any patient who had what we considered a serious mental disorder.

We do not believe some eight years ago when in the course of a normal days general business that it was the proper procedure to tell Mr. Lembcke that he could take the patient out of the hospital. Mr. Lembcke had to be investigated by the Social Service Department.

We had to have the permission of relatives and we had to have the staff's opinion that the patient was ready to be let out.

[93]

As I recall, the procedures were not carried out.

Set 3, 42-A, did you write a hand-written note to Doctor Gumanis dated 11/25/64 recommending a negative answer to Mr. Lembcke's letter of November 23, 1964? Yes, sir.

Set 2, 36, in this note you also used as reasons for denying Mr. Lembcke's request the necessity for parental consent and knowledge about Mr. Lembcke.

Why did you deny Mr. Lembcke's request rather than tell him that parental consent was necessary? Why did you deny his request rather than to ask Mr. Lembcke to supply more information about himself? I have no recollection.

In the note you write, "etc., etc.," after the reasons given for denying Mr. Lembcke's request. State all other reasons for denying Mr. Lembcke's request. I have no recollection.

Set 3, 42-E, what was the relationship between plaintiff and Mr. Lembcke? I do not know.

Set 2, 24, state in detail what transpired during your interview with John

Lembcke when he visited Florida State Hospital in Chattahoochee in May of 1966? To the best of my knowledge, Mr. Lembcke did not have an interview with me.

Set 1, 31-A, is it true that at a staff con-

[94]

ference held on March 21, 1968, the conference recommended releasing plaintiff on conditional release for out-of-state discharge on certain conditions, including parental approval could be met. The medical report contains this information.

If so, was the decision not to follow said recommendation by you? No. This decision would have to have been made, if indeed it was made, by the clinical director. I made a statement in a memo that it appeared that Mr. Lembcke, an individual who was seeking custody of Donaldson, would not properly supervise the patient. My opinion was not a final decision on this matter.

Set 3, 43-A, did you write a hand-written note to Doctor Hanenson dated 6/17/68, contained in plaintiff's hospital record? Yes.

Set 3, 43-B, that notes states that "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise this patient."

What was the date of the prior decision that Mr. Lembcke would not properly supervise plaintiff? I do not recall.

Set 3, 43-K, name all doctors at Florida State Hospital other than yourself who felt that Mr. Lembcke would not properly supervise plaintiff if plaintiff were released in his care? I have no recollection of the names of such doctors, since it refers to a period of about 10 years ago.

MOTION FOR DIRECTED VERDICT

[97]

MR. MAHORNER:

If Your Honor please, we would respectfully move for a directed verdict at this time on the basis that the evidence before the Court conclusively shows not necessarily that Mr. Donaldson was dangerous, but it does, from a directed verdict standpoint, show substantially he was in fact sick, or there was a reasonable belief to believe that he was sick.

The law at that time prior to the passage of the Baker Act in the last year provided for the institutionalization of both the sick and the dangerous and it was a conjunctive requirement and we submit that the later change in the law or even if that law now be held unconstitutional should

[98]

not be foundation for a many judgment against the defendants who were only proceeding in a manner that was specifically authorized.

We respectfully say to the Court that under color of law as provided in the Civil Rights Act does not mean the same thing as acting as required by law, and if you are required by law to so hold, then we suggest that there is no case.

THE COURT:

That motion will be denied. Call the jury back in.

TESTIMONY OF DR. F. G. WALLS--Cross Examination

[118]

A Very Well. I am having difficulty finding it.

Q Well, I will show you my copy, sir, so you can read from it.

A §42. I have it now. I have the copy, June 2nd.

Q Alright, now, you asked to answer some questions at that time and I call to your attention question number two which was asked of you.

The question was, "is Mr. Donaldson a danger to himself or to society?"

Your answer was, "Mr. Donaldson, so far as one can make out, has not proved himself to be a physically agressive individual in this hospital who in the usual sense of the question as we understood it could be considered dangerous."

A That is correct.

Q And it is still your opinion that Mr. Donaldson is not a physically dangerous person?

A I cannot answer that.

Q Was it your opinion at the time you answered this letter?

A Yes, sir.

Q I call your attention to the fourth question, the question was, "what treatment does he presently receive?"

And was your answer not, and I quote, "the only treatment this patient receives is that of what is

[119]

broadly known as milieu therapy, which in the main means that he is in a totally protected environment where his every needs are taken care of and where if he becomes physically ill, medical attention is at hand."

A Yes.

Q And I believe you testified in your deposition that by milieu therapy, that phrase milieu therapy means the same thing today as the phrase custodial care used to mean, is that correct?

A I don't know.

Q Is that your understanding?

A I don't recall testifying to that.

Q You don't?

A No.

Q On page 165 of your deposition --

THE COURT:

First, is there any difference?

THE WITNESS:

No, I don't think there is a great difference, Your Honor, but I think it is a play on words.

MR. ENNIS:

Q Page 165 of your deposition when you were asked to explain briefly what milieu therapy means, did you not answer "custodial care is what we now call milieu therapy"?

[120]

A Yes, sir, if you say so, I said that.

Q I believe Mr. Mahorner asked you something about your qualifications.

A Yes.

Q And I wasn't quite clear of the answer. You are not licensed to engage in private practice of medicine in the State of Florida, are you?

A No, sir.

Q You could not treat psychiatric patients on an out-patient basis in the State of Florida?

A No, sir.

Q We referred a minute ago to the deposition. That was the deposition that was taken approximately two weeks after Mr. Donaldson was

was discharged as having regained competency, is that correct?

A That was exactly 13 days.

Q And before your deposition Mr. Donaldson was deposed, is that correct?

A Yes, sir.

Q And, you were present and heard the answers he gave at that time?

A Possibly ten to fifteen minutes or maybe half an hour.

Q Now, was it your opinion at that time two weeks after his discharge that he was in worse mental condition

TESTIMONY OF DR. CLARK ADAIR--Direct Examination

[137]

Q Does institutionalization, itself, can that help in the cure of paranoid schizophrenic conditions?

A It is a matter of opinion. I feel that proper institutionalization and the proper kind of institution does have benefits, treatment benefits. By proper I mean that there is a good mileau which is really a treatment in itself yes, I think in cases, many, many cases are important that institutionalization itself seems to help the patient.

A Do you know from your notes if the patient refused electro-shock treatments?

[138]

A Do I know if this patient did?

Q Yes.

A I recall that he didn't want to accept treatment but I think -- I don't know if he refused it. From my notes I suggested that I had very little intent if I had any intent of using shock treatment.

I mentioned in my notes that that was -- that would be routine in the case that I considered as ill as he was, but I don't think it was particularly indicated and he may have refused.

I probably wouldn't have given it to him anyhow, whether he refused it or not, under any conditions.

I think in my notes I mentioned that if there was an episode that I might like to have permission to use it, but otherwise, I wouldn't.

[147]

MR. MAHORNER:

Q What is the primary method of treatment used for paranoid schizophrenia?

A Mr. Mahorner, I don't think there is any primary method of treatment. It depends a great deal on the individual patient, his needs, the degree of illness, electro-shock treatment is used, and back earlier, insulin and metrosol was used, group therapy, your activity therapy, various forms of treatment of this sort, a combination of treatment.

Q Is cheno therapy used?

A Yes, sir.

Q How much money is spent at the hospital in Chattahoochee on drugs for chemical therapy?

A Mr. Mahorner, I couldn't answer directly, without referring to the records. Medical drugs and medical supplies would be somewhere in the neighborhood of, I would say roughly about $300,000.00 a month.

[148]

Q $300,000.00 a month?

A Yes.

Q For just Chattahoochee?

A Yes, sir. This is a rough estimate. Wait a minute, I beg your pardon, but I didn't mean a month. A year.

Q What was your last year's as head of the hospital at Chattahoochee?

A I was relieved of the responsibility of the superintendent's position in 1963. I have been serving in a dual capacity from 1957 to 1963. I had been superintendent from 1950 until the appointment of a Division Director and then continued on in both positions until 1963.

Q Now, while you were there did you have on an involuntary basis, patients that needed mental treatment, but who had not been specifically diagnoses as dangerous?

A Would you repeat the question?

Q Did you have on an involuntary basis, patients who needed mental treatment but who had not been specifically diagnoses as dangerous?

A Oh, yes, certainly, and the diagnosis of the patient as dangerous or non-dangerous might enter into whether he was released at a certain time, either on discharge or trial visits, but many patients came to the institution both on involuntary admission and voluntary admission status that

[149]

was in need of treatment and during certain

times of their illness they would express a great deal of hostility in their delusion thinking and so forth, and at one time reacting to these as you might have a person who might be considered dangerous at a given time and not at another, or after following treatment.

Q I draw your -- I want you to look at -- do you recall ever going to a staffing for Mr. Donaldson?

A Yes, sir, I looked at the records, but I don't remember the occasion, but in 1962 apparently, I did set in on a staff conference at this time.

During that period of time while I was serving in a dual capacity when other duties would allow it I would visit certain areas of the hospital and set in on staff conferences and so forth, but this was not, you know, a regular thing because of other requirements and responsibilities.

Q Do you remember what your opinion was at staff in 1962?

A According to the staff records I agreed with the diagnosis and recommendation that Mr. Donaldson, you know, should continue treatment.

Q Now, if the hospital had a patient who was clearly not dangerous but let's say needed treatment because he was incompetent to handle his own affairs, would you keep

[150]

him there on a voluntary basis?

A On a voluntary basis.

Q Let me correct that, on an involuntary basis. This was back then. I am not talking about now.

A We have always had in effect there a procedure for releasing a patient on a trial visit. It was known as a trial visit. This was a decision made by the treating psychiatrist.

He can release the patient to family, guardian or to some responsible person who would assure the hospital of adequate care and supervision of the patient.

A large number of patients went out under the trial visit arrangement. Some were for short periods of stay and others remained out for a full year and then was discharged at the end of the year by virtue of being absent one year on a trial visit and the assurance that the patient was making satisfactory adjustment.

Persons taking patients out were supposed to report to the hospital every thirty days in writing as to the adjustment the patient was making.

Q Was it customary on a trial visit to have a person come down to the hospital to be seen by the physicians on a trial visit a person who was taking over the patient, would he be required generally to come down to the hospital?

A Oh, yes, always the person signing the trial

[151]

visit certificate would come to the hospital and recieve the patient.

Now, in a few instances the blanks would be mailed to an individual and they would sign them and then send another person to actually bring the patient home, but in a majority of the cases, the individual taking the responsibility would come to the hospital and sign the trial visit.

Q Is it possible for a patient to need intensive treatment and yet not be dangerous?

A Well, certainly.

Q And where that type of treatment was needed you would keep them in the hospital on an involuntary basis?

A If treatment was needed and there was no -- it couldn't be provided elsewhere, either by arrangement with a private facility or in the community and treatment was needed, yes.

Q What was the procedure used as far as trial visits in relation to yourself as superintendent? Did you approve those visits?

A No, this was -- the attending physician had the authority to grant a release on a trial visit.

TESTIMONY OF DR. JESUS S. RODRIGUEZ--Direct Examination

[167]

Q Did you propose group therapy and chemotherapy?

A Oh, sure.

Q And each time the patient refused?

A Refused. He said he needed to talk with his lawyer. I don't know how to pronounce it.

Q Birnbaum?

A That is right.

Q Did the patient ever refuse a release in your presence?

A Well, the only way to release a patient is through the staff or a trial visit, but he refused trial visits. He said he wanted to go to a Court and also I talked with Doctor Paizer at that time who was a professor from the State University here in Tallahassee who was doing a research at that time and I say if he want to take this patient and give group therapy, but the patient refused.

Q Refused group therapy?

A Yes.

TRANSCRIPT OF PROCEEDINGS

11/28/72

PROCEEDINGS

November 28, 1972

[13]

(The following is the deposition of J. B. O'Connor, M.D., on written interrogatories, and was read to the Jury as follows:)

Q "Describe your professional qualifications, your professional education, training and experience."

A I graduated as a Doctor of Medicine in June, 1935 from the University of Georgia Medical College at Augusta, and then had a two-year rotating internship at the Duval County Hospital in Jacksonville. And then joined the staff of the Florida State Hospital in July, 1937. And then entered the United States Army in August, 1942, from which I was discharged in February, 1946.

I attended the School of Military Neuropsychiatry in the Spring of 1943 at Lawson General

[14]

Hospital in Atlanta and then was appointed Chief of the Neuropsychiatric Section of the 262nd Station Hospital, which shortly sailed for North Africa and Italy.

Upon eventual release from the Army, I rejoined the staff of the Florida State Hospital in 1946 and remained until I entered partnership in 1949 with Doctor William H. McCullough in Jacksonville in the practice of psychiatry.

Because of the strenuous nature of this practice, I discovered I had hypertension on a life insurance examination and determined that I had to have a more relaxing type of practice and thereupon retired to the Florida State Hospital on the staff.

This was found to be, however, not as relaxing as I had hoped, but rather even more exacting of my health.

I remained at the Florida State Hospital, gradually being promoted to Assistant Clinical Director, then to Clinical Director, and eventually to Superintendent, which last promotion took place in, I believe, July of 1963. I remained as Superintendent until my retirement for the above-mentioned medical reasons, as of February 1, 1971.

Q "Approximately what date did your period of employment at Florida State Hospital begin?"

A Approximately July, 1937.

Q "What date did you retire?"

[15]

A As of February 1, 1971.

Q "Was your employment between those two dates continuous?"

A No. It was interrupted by at least three and a half years by service in the United States Army during the war and by at least two years in private practice in partnership with Doctor McCullough in Jacksonville from 1949 to 1951.

Q "In what various capacities did you serve at Florida State Hospital and give the approximate dates?"

A I became a resident of the staff July 5, 1937 and then was on leave to the military service from September 1, 1942 to about February, 1946, and returned to the Florida State Hospital on that last mentioned date and remained at the hospital until joining Doctor William H. McCullough in Jacksonville in a partnership engaged in the practice of psychiatry on March 15, 1949.

I returned to the hospital from the last mentioned position again as a staff physician April 1, 1951, and was promoted to Assistant Clinical Director November 19, 1952 and then to Clinical Director July 1, 1959, and finally to Superintendent July 30, 1963, and retired February 1, 1971.

Q "Describe generally your duties in each capacity."

A Initially at Florida State Hospital my duties

[16]

were primarily checking histories and physicals and prescribing therapy of both the psychiatric and physical needs of patients committed to the Florida State Hospital.

My duties as Assistant Clinical there were to carry out the directions of the Superintendent and the Clinical Director as regards the care and management of patients at the Florida State Hospital.

My duties as Clinical Director were of a similar nature to those just mentioned, with the addition of considerably more responsibility attached to my duties and considerably more judgment required in determining how such could best be effected.

As Superintendent I was in charge of the whole Florida State Hospital, including not only the care and maintenance of the patients, but also the maintenance of the structures of the hospital; the supervision of the new construction that would occur from

time to time, seeing that proper and adequate supplies - both medical and otherwise - were obtained at the hospital and properly distributed; the selection and guidance of the medical and nursing and ancillary staffs of the hospital; and considerable interest attached to making recommendations for appropriations and justification for same; and, of course, the day-to-day upkeep of the physical plant, which at the Florida State Hospital amounts practically to being an

[17]

independent city, supplying and maintaining its own power and heating and lighting and water and sewage systems, and of course, the maintenance of the structures, probably something over 100 in all, that were on the hospital grounds; and attempting to see that the five or 6,000 usual number of patients were given the best care that the small staff cound furnish.

Q "Approximately what date did you first meet Kenneth Donaldson?"

A I can't say that I recall the exact date. It would be my assumption from various references to his case that it must have been in the summer of 1957 or '8.

Q What was the occasion of that meeting, and describe it briefly.

A I have no recollection of that particular meeting.

Q To the best of your recollection, what subsequent meetings did you have with Kenneth Donaldson?

A I cannot isolate and describe any such meetings. It would just be my assumption that it would be in reference to some point being raised by his attending psychiatrist, and presumably took place in the area of the hospital where the patient resided.

Q Did you ever have occasion to meet and talk with Kenneth Donaldson alone; that is, without other members

[18]

of your staff present? If so, to the best of your recollection, describe what took place at each of those meetings."

A I recall that one of his attending psychiatrists was Doctor Hannonson, who subsequently dies while on the staff of the hospital, but I don't remember the exact incident of the meeting. I do recall that a clinical psychologist from Jacksonville, whose name I think is Doctor Calhoun, accompanied a Mr. Starling, a Representative in the Legislature from Duval County, who I believe visited the hospital at the specific request of the patient mentioned and was seen on that occasion not only by the patient, but by his attending psychiatrist, Doctor

Gumanis, and the Chief Psychologist of the hospital, Mr. Julian Davis, by myself and Mr. Starling, and I think - though I am not certain - that some other member of the staff may have been present on that occasion at this meeting in my office.

The patient himself, however, was seen alone on this occasion by Doctor Calhoun in the area of the hospital where the patient normally resided.

Q "Did you ever have occasion to reprimand Kenneth Donaldson, delivering such reprimand yourself, personally, or through your staff in such a way that he would know the reprimand was coming from you? If so, describe the circumstances."

[19]

A I don't specifically recall any reprimand.

Q "To the best of your recollection, state the approximate date that you were present at 'General Staff' concerning Kenneth Donaldson."

A I cannot recall such dates, but it would be a matter of record in the patient's file at the hospital.

Q "What occurred on these occasions?"

A It would be my belief that the same occurred as occurred on the appearance of any patient before the General Staff, consisting of the patient's case being presented by his attending psychiatrist,

the patient being called in and being interviewed by the members of the staff present, and then by the patient's exit and the secretary being called in to take down the opinions of each of the members present.

Q "To your knowledge and recollection, was Kenneth Donaldson ever presented to staff other than the above occasions in which you were present?"

A It is my understanding that he had been presented to staff on occasions when I was not present.

Q "Was 'Staffing' of an individual patient scheduled at regular intervals or was the procedure each time initiated on a need basis?"

A It was initiated by the patient's attending psychiatrist in order to determine what the consensus of

[20]

opinion of the staff was as to whether any particular patient should be granted a release from the hospital.

MR. MAHORNER:

I would like to approach the bench with counsel a moment, Your Honor.

(Whereupon, the attorneys approached the bench.)

MR. MAHORNER:

Could you give me the last question, Mr. Reporter, please?

(Whereupon, the Court Reporter read the last question, as requested.)

BY MR. MAHORNER:

Q "If on a need basis, who would determine the need and initiate the proceedings?"

A The patient's attending psychiatrist.

Q "Were patients ever 'Staffed' at their own request?"

A That has happened at the Florida State Hospital, but would have to have the concurrence of his attending psychiatrist since he would be the one that would present the case.

Q "If so, was Kenneth Donaldson ever staffed at his own request?"

A I do not have any distinct recollection that

[21]

this occurred, though it may have.

Q "Describe generally the staffing procedure. Would all the doctors on the Florida State Hospital be present?"

A Not invariably would all the doctors be present.

Q "How would the patient be presented?"

A I have described that previously, consisting of the case being read and discussed by the patient's attending psychiatrist, but the patient himself being brought into the room and questioned in detail by each of the members of the staff present.

Q "What was your individual function at staffing?"

A I would invariably, when present, which by no means was very often because of my conflicting other duties at the hospital, be the last to express my opinion since I did not wish any of the staff members to think that I was putting any pressure upon them to agree with my opinion.

Q "Why did you vote last, that is, after the other staff voted?"

A I thought it was the fair thing to do so they would not be intimidated by any aura of authority being present.

Q "Could you, if you wished, overrule the vote of the rest of your staff?"

[22]

A Possibly technically, but not practically, because the purpose of the staff was to obtain the consensus of opinion of the staff of the hospital as to a particular case.

Q "If you could, did you ever do so? If yes, describe the occasion, including those

occasions involving patients other than Kenneth Donaldson."

A I have no recollection of ever doing so.

Q "To the best of your recollection and knowledge, what were the procedures at Florida State Hospital during the period of your employment for release of patients on trial visits?"

A The typical trial visit was handled by the patient's attending psychiatrist, since he had the most intimate knowledge of a particular case than would other members of the staff, and would most probably have been also in touch with the patient's relatives and perhaps Social Service.

Q "Were these procedures consistently followed for all patients?"

A It is my belief that they were.

Q During the period of your employment at Florida State Hospital do you recall instances of patients, other than Kenneth Donaldson, asserting that they were wrongfully committed to Florida State Hospital because of

[23]

insufficient Florida residency? If so, how were these cases handled?"

A Yes.

Q "To the best of your recollection and knowledge, during the term of Kenneth

Donaldson's commitment at Florida State Hospital, were any investigations or efforts made by the staff of the hospital regarding transfer of Kenneth Donaldson to another state?"

A Yes.

Q "If so, describe these efforts and name the other state or states to which these efforts were directed."

A It is my recollection that the patient himself early brought this possibility to the attention of the hospital authorities and I recall, I believe, that Doctor W. D. Rogers, who was the Superintendent, took up this matter with the New Jersey Hospital system authorities and it is my understanding he received a negative reply that this patient was a resident of that state and therefore eligible for hospitalization there.

Q "Was it your professional opinion during the time that Kenneth Donaldson was hospitalized at Florida State Hospital that such hospitalization was necessary?"

A It is my belief that this is a matter that was determined by the committing court and that the commitment was therefore proper for the hospital to receive this patient,

[24]

since it was understood that it was not the duty of the Superintendent of the hospital to question the right or wisdom of a court in committing a patient, but

rather to determine whether that patient having once reached the hospital was in such condition as to request that he be considered for release from the hospital.

Q "Was there any time during Kenneth Donaldson's hospitalization at Florida State Hospital that you did not feel that such hospitalization was necessary?"

A My concept of this case and of practically every other case at the Florida State Hospital was based upon the reports made by those members of the medical staff as to the condition of any particular patient at any particular time, and from all the information I had neither the individual physician in care of this case nor the collective opinion of the staff when considering this case on various occasions was ever to the effect that this patient had recovered from his psychiatric disability to the extent that he could manage his own affairs if released from the hospital and was considered to be mentally competent at that time.

Q "Did you believe that Kenneth Donaldson was a person in need of care or treatment and because of his illness lacked insufficient insight and capacity to make responsible application therefore?"

[25]

A I did, in view of the reports that I was furnished by his attending psychiatrist as to his mental condition.

Q "If the answer is yes, was the need that of care or treatment, or both?"

A It would be my recollection that any one of those described needs would at that time have required his remaining in the Florida State Hospital.

Q "If the answer is that he did need care or treatment, explain the nature of such care and/or treatment needed."

A Initially he was considered by the staff as unable to take care of himself in the world and also it is my recollection the staff thought that he would benefit from further treatment.

Q "Did he receive this treatment?"

A This patient on numerous occasions was offered treatment and would refuse to accept treatment that on the basis of his opinion there had never been anything wrong with his mind, including the particular times when such treatment would be offered him.

Q "If now, why not?"

A As stated above, he consistently refused any treatment and would even at times, now that I think of it, refuse certain testing to see what his condition was by the

Psychology Department.

Q "In approximate terms and to the best of your recollection, what was the patient population at Florida State Hospital when you first became employed there?"

A I don't recall the exact figure, but it would be my estimate that it was approximately 5500 patients, but I cannot be sure because I know that at one time during my stay there, there was 6800 patients and had dropped down to about, I believe, 4800 at the time I left.

Q "What was the patient population at Florida State Hospital at the time of your retirement?"

A My recollection is that it would have been about 4800, but this is a matter of official record, which can easily be obtained from the records which I do not have.

Q "During the time that you were a staff member at Florida State Hospital, and later as an administrator, did you ever assert a conscious effort to reduce the patient population at Florida State Hospital? If so, what sort of effort did you make?"

A I certainly did constantly, and I think the hospital records will reveal that the patient population showed a constant decrease during the time that I was an administrator at the Florida State Hospital. The efforts were chiefly manifested by a constant attempt to get more patients released from the hospital and to make every effort

[27]

to see that such was accomplished, keeping in mind that there was also an obligation on the part of the staff not to release those patients whom we did not think had a good chance of adjusting in society.

Q "At the time that you first became employed at Florida State Hospital, how many doctors were on the Florida State Hospital Staff?"

A I don't recollect the exact figure, nor was it my duty to do so, since I was just a member of the staff at that time, but it would be my belief that there was probably a dozen.

Q "When you retired, how many doctors were there?"

A This again is a matter in which I have no exact recollection, but it is a matter that can easily be determined since there is official information contained by the Division of Mental Health Office in Tallahassee and at the Florida State Hospital. My educated guess would be that there must have been something around twenty-five.

Q "As an administrator, did you ever assert a conscious effort to obtain additional staff doctors?"

A I certainly did, and even put advertisements in various medical publications, announcing a need there to increase the staff of the hospital.

Q "If so, how did you assert this effort?"

[28]

A As described above and by frequent correspondence with various potential and actual applicants.

Q "During the term of Kenneth Donaldson's commitment at Florida State Hospital, was he ever examined by a psychologist or psychiatrist who was not a member of the hospital staff?"

A Yes. As has been previously described such a psychologist practicing in Jacksonville accompanied Representative Starling to the hospital at the express request of the patient, so I understand.

Q "If so, describe to the best of your knowledge and recollection the occasions and the individuals who conducted the examinations."

A This has been described above in the same group of questions, but I will repeat that Representative Starling and a Doctor Calhoun, introduced as a clinical psychologist from Jacksonville, visited the Florida State Hospital after first contacting my office and being given every assurance that every facility available would be made at their convenience. They did this at the hospital together one Saturday morning and met in my office, and others present besides myself, and those mentioned were Doctor Gumanis, the patient's attending psychiatrist, and Mr. Julian Davis, the Chief Psychologist of the hospital, who was quite familiar with this case, and I believe someone else was present, but I

[29]

cannot be positive as to which individual it was, since it has occurred so long ago, though I do believe that the hospital records might reveal this fact if needed.

Q "If such examination did occur, were the results communicated to you?"

A Only indirectly, since this psychologist was present for the benefit of the patient, and presumably for Mr. Starling, and if I recall correctly they were communicated to me by my receiving a copy of a letter consisting primarily of a brief report by Doctor Calhoun to a lawyer in Quincy.

Q "If so, what were the results?"

A The results are a matter of record and it is my present recollection that the report indicated that this patient in this psychologist's opinion was by no means recommended for discharge from the hospital and, if I am not in error, indicated that such a proceeding might be dangerous. Again this is a matter of record which has already been made available to the attorneys on both sides of this case.

[39]

Q "Did you, in any of your capacities, require individualized treatment plans for patients at Florida State Hospital, and, if not, why not?"

A I don't quite understand the exact meaning of the question since it would be my presumption that every patient in the hospital had an individualized treatment plan developed by his own attending psychiatrist and at times discussed by the general staff of the hospital.

Q "Did you in any of your capacities, require periodic review of treatment plans for patients at Florida State Hospital, and, if not, why not?"

A The general staff of the hospital as a part of its function would often be involved in giving their collective opinion as to treatment of various cases in the hospital.

Q "Describe every effort that you, in any of your capacities, made to create a humane environment at Florida State Hospital."

A It is my belief that at all times and every day in the year attempts were constantly being made to give what has been called above a humane environment, both as to the living conditions, as to the nourishment of the patients, as to the bedside care of additional other patients, and similar such activities, if these can be called humane.

[46]

Q "Indicate Plaintiff's treatment plan by page and date."

A This would be incorporated no doubt in progress notes made by the patient's attending physician and not by me, since it was not my function at the hospital to attend to such matters in every case in the Florida State Hospital over the years.

Q "Indicate every modification or review of Plaintiff's treatment plan, by page and date."

A Every time the patient appeared before the General Staff of the Hospital or every time the patient

[47]

appeared before the psychologists of the hospital and every time the patient appeared before his own attending psychiatrist would indicate either the need or the lack of need of any particular change in the plan of his treatment. These were matters that were not under my immeidate care.

ORAL CHARGE

November 28, 1974

THE COURT:

Ladies and gentlemen of the Jury, now that you have heard the evidence in this case and the arguments of counsel it is my duty to give you the instructions of the Court as to the law which is applicable to this case.

It is your duty as jurors to follow the law as stated in the instructions of the Court, and to apply the rules of law so given to the facts as you find them from the evidence in this case.

You are not to single out any one instruction alone as stating the law, but you must consider the instructions as a whole as the law applicable to this case.

Neither are you to be concerned with the wisdom of any rule of law. Regardless of any opinion you may have as to what the law ought to be, it would be a violation of your sworn duty to base a verdict in this case upon any other view of the law than that given by the Court, just as it would be a violation of your sworn duty as jurors in this case as judges of the facts to base a verdict upon anything except the evidence that have been presented in this case.

Justice through trial by jury must always depend upon the willingness of each juror to speak the truth as to the facts from the same evidence presented to all of the

[3]

jurors and to arrive at a verdict by applying the same rule of law as given in the instructions of the Court.

The Jury should consider each instruction given to apply separately and individually to the Plaintiff and to each Defendant in this case and I would remind you that this case is a suit against three individuals as Defendants and each case should be considered by you separately.

You have been chosen and sworn as jurors in this case to try the issues of fact presented by the allegations of the complaint of the Plaintiff, also claims contained in the complaint, and the answer and defenses raised by the Defendants. You are to perform this duty without bias or prejudice as to any party.

Our system of law does not permit jurors to be governed by sympathy, prejudice, or public opinion. Both the parties and the public expect that you will carefully and impartially consider all of the evidence in the case, follow

the law as stated by the Court and reach a just verdict regardless of the consequences.

This case should be considered and decided by you as an action between persons of equal standing in the community, of equal worth and holding the same or similar stations in life. The law is no respector of persons. All persons stand equal before the law and are to be dealt with as equals in a court of justice.

[4]

Specifically, you are instructed that you are to weigh the credibility of the Plaintiff, Kenneth Donaldson, just as you would weigh the credibility of any other witness. The fact that he was for many years a patient in a mental hospital would not in and of itself justify you in disregarding his testimony if it is otherwise believable.

Now, the burden is on the Plaintiff in a Civil action to prove every essential element of Plaintiff's claim by a preponderance of the evidence in the case, the Jury should find for the Defendants.

To establish by a preponderance of the evidence means to prove that something is more likely so than not so. In other words, a preponderance of the evidence in

the case means such evidence as, when considered and compared with that opposed to it, has more convincing force, and produces in your minds belief that what is sought to be proved is more likely true than not true.

In determining whether any fact in issue have been prepared by a preponderance of the evidence in the case the jury may, unless otherwise instructed, consider the testimony of all witnesses, regardless of who may have called them and all exhibits received in evidence regardless of who may have produced those exhibits.

[5]

There are generally speaking two types of evidence from which a jury may properly determine the truth as to the facts in a case.

One is direct evidence, such as the testimony of an eyewitness. The other is indirect or circumstantial evidence, the proof of a chain of circumstances pointing to the existence or non-existence of certain facts.

As a general rule, the law makes no distinction between direct and circumstantial evidence, but simply requires that the Jury find the facts in accordance with the preponderance of all the evidence in the case, both direct and circumstantial.

You are not bound to decide any issue of fact in accordance with the testimony of any number of witnesses which does not produce in your minds belief in the likelihood of truth, as against the testimony of a lesser number of witnesses or other evidence which does produce such belief in your minds.

The test is not which side brings the greater number of witnesses, or presents the greater quantity of evidence; but which witness, and which evidence, appeals to your minds as being most accurate, and otherwise trustworthy.

Statements and arguments of counsel are not evidence in the case. When, however, the attorneys on both sides stipulate or agree as to the existence of a fact, the

[6]

Jury must, unless otherwise instructed, accept the stipulation and regard that fact as proven.

There has been some stipulations of fact placed before you. Unless you are otherwise instructed, the evidence in the case always consists of the sworn testimony of the witnesses, regardless of who may have called them; and all exhibits received in evidence, regardless of who may have produced them; and all facts and events which

may have been judicially noticed; and all applicable presumptions stated in these instructions.

Now, any evidence to which the Court has sustained an objection may not be considered by the Jury in any manner in arriving at a verdict in this case. Anything that you may have heard or seen outside of this courtroom is not evidence and it would be entirely disregarded by you in arriving at a verdict in this case.

You are to consider only the evidence in this case as presented from this witness stand, but in your consideration of the evidence you are not limited to the bald statement of the witnesses.

In other words, you are not limited solely to what you see and hear as the witnesses testify. You are permitted to draw from facts which you find have been proved such reasonable inferences as seem justified in the light of your experience.

[7]

Each party has introduced into evidence certain interrogatories of the Defendant, Dr. O'Connor, that is, questions, together with answers signed to and sworn to by this party.

A party is bound by his sworn answers.

By introducing an opposing party's answers to interrogatories, however, a party does not bind himself to these answers, and he may challenge them in whole or in part or may offer contrary evidence.

During the trial of this case, certain testimony has been read to you by way of deposition, consisting of sworn written answers to questions asked of the witness in advance of the trial by one or more of the attorneys for the parties to the case. The testimony of a witness who, for some reason, cannot be present to testify from the witness stand may be presented in writing under oath, in the form of a deposition. That testimony is entitled to the same consideration, and is to be judged as to credibility, and weighed, and otherwise considered by the Jury, in so far as possible, in the same way as if the witness had been present, and had testified in person.

Now, you, as jurors, are the sole judges of the credibility of the witnesses and the weight their testimony deserves. You may be guided by the appearance and conduct of the witness, or by the manner in which the

[8]

witness testifies, or by the character of the testimony given, or by evidence to the contrary of the testimony given.

You should carefully scrutinize all of the testimony given, the circumstances under which each witness has testified, and every matter in evidence which tends to show whether a witness is worthy of belief. Consider each witness' intelligence, motive and state of mind, and demeanor and manner while on the stand.

Consider the witness' ability to observe the matters as to which he has testified, and whether he impresses you as having an accurate recollection of these matters.

Consider also any relation each witness may bear to either side of the case, the manner in which each witness might be affected by the verdict, and the extent to which, if at all, each witness is either supported or contradicted by other evidence in the case.

Inconsistencies or discrepancies in the testimony of a witness, or between the testimony of different witnesses, may or may not cause the Jury to discredit such testimony. Two or more persons witnessing an incident or a transaction may see or hear it differently; and innocent misrecollection, like failure of recollection, is not an uncommon experience. In weighing the effect of a discrepancy, always consider whether it pertains to a matter of importance or an unimportant detail, and whether the discrepancy

results from innocent error or intentional falsehood.

After making your own judgment, you will give the testimony of each witness such weight, if any, as you may think it deserves.

The rules of evidence ordinarily do not permit witnesses to testify as to opinions or conclusions. An exception to this rule exists as to those whom we call "expert witnesses". Witnesses who, by education and experience, have become expert in some art, science, profession, or calling, may state their opinions as to relevant and material matter, in which they profess to be expert, and may also state their reasons for the opinion.

You should consider each expert opinion received in evidence in this case, and give it such weight as you may think it deserves. If you should decide that the opinion of an expert witness is not based upon sufficient education and experience, or if you should conclude that the reasons given in support of the opinion are not sound or if you feel that it is outweighed by other evidence, you may disregard the opinion entirely.

The opinion of a doctor as to the condition of a patient may be based entirely upon objective symptoms, revealed through observation, examination, tests or treatment; or the opinion may be based entirely upon subjective symptoms, revealed only through statements made by the patient; or the

[10]

opinion may be based in part upon objective symptoms, and in part upon subjective symptoms.

To the extent that any opinion testified to by a doctor is based upon subjective symptoms described to him by a patient, the Jury may of course consider the accuracy of the patient's statements, in determining the weight to be given the doctor's opinion.

The Plaintiff in this case claims damages for personal injuries, alleged to have been suffered or sustained by him as the result of the deprivation, under color of state law, statute, regulation, custom or usage of a right and privilege and immunity secured to plaintiff, both by the Constitution of the United States, and by an Act of Congress providing for equal rights of all persons within the jurisdiction of the United States.

Section 1983 of Title 42 of the United States Code, which is the applicable statute involved, provides that any inhabitant of this Federal District may seek redress in this Court, by way of damages, against any person or persons, who under color of state law, statute, regulation, or custom, knowingly subject such inhabitant to the deprivation of any rights, privileges, or immunities, secured or protected by the Constitution or laws of the United States.

Now, the purpose of the statute just outlined to you, I will explain to you.

[11]

treatment during the particular period or periods Plaintiff refused such treatment.

In order to prove his claim under the Civil Rights Act, the burden is upon the Plaintiff in this case to establish by a preponderance of the evidence in this case the following facts:

That the Defendants confined Plaintiff against his will, knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness.

Second, that the Defendants' then and there acted under the color of state law.

Third, that the Defendants' acts and conduct deprived the Plaintiff of his Federal Constitutional right not to be denied or deprived of his liberty without due process of law as that phrase is defined and explained in these instructions, and fourth, that the Defendants' acts and conduct were the proximate cause of his injury and consequent damages that he suffered.

Now, I mentioned the word that the Defendants knowingly acted in the last instruction. An act is knowingly done

if done voluntarily and intentionally and not because of mistake or accident or any innocent reason.

Now, the Defendants in this action have claimed and are relying on the defense that they acted in good faith.

[13]

Simply put, the Defendants contend they in good faith believed it was necessary to detain Plaintiff in the Florida State Hospital for treatment for the length of time he was so confined.

If the Jury should believe from a preponderance of the evidence that the Defendants reasonably believed in good faith that detention of Plaintiff was proper for the length of time he was so confined then a verdict for Defendants should be entered even though the Jury may find the detention to have been unlawful.

However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify Plaintiff's confinement in the Florida State Hospital.

As a corollary Plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual

deprivation of constitutional rights or other rights guaranteed by law.

As to this defense of good faith, the burden is upon the Defendants to prove this defense by a preponderance or a greater weight of the evidence in the case.

By acts done under color of state law, not only where the State officials act under color of law, that is, state law, not only where the officials act within the bounds

[14]

or limits of their lawful authority, but also when such officers act outside of and beyond the bounds of their lawful authority.

In order for unlawful acts of an official to be done under color of any law, however, the unlawful acts must be done while the official is purporting or pretending to act in the performance of his official duties, that is to say, the unlawful acts must consist in an abuse or misuse of power which is possessed by the official only because he is an official and the unlawful acts must be of such a nature, and be committed under such circumstances, that they would not have occurred but for that, that the person committing them was an official purporting to exercise his official duties or powers.

Now, as you will note, the federal statute which the Defendants have alleged to have violated covers not only acts done by an official under color of any State law, but also acts done by an official under color of any regulation of the State, and even acts done by an official under color of some State or local custom, so the phrase under color of State law includes acts done under color of any State law or any regulation or any State or local custom.

You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such treatment as wil give

[15]

him a realistic opportunity to be cured or to improve his mental condition.

Now, the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others. Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that the Plaintiff was dangerous to either himself or others.

[975]

PLAINTIFF'S EXHIBIT NO. "1"

INFORMATION BLANK
FOR
FLORIDA STATE HOSPITAL

(To be fully filed out by the physicians of the Examining Committee when the patient is before them, attached to the Commitment papers and sent with the patient to the hospital.)

Social Security No. _____

Full Name of Patient Kenneth Donaldson

Sex Male Color white

Marital State: D Religion ___ Age ___

Occupation Painting and carpenter work

War Service _____ Height 5 ft. 9 Inches

Weight 165 lbs. Where born Erie Penn.

Date: Day ___ Month May Year 1906

Father's Name William T. Donaldson

Where Born Kingston, N. Y.

Mother's Maiden Name Marjorie K. Whitbeck

Where Born Kingston, N. Y.

How long has patient been in State of Florida? about 4 years

Has Legal Guardian been appointed? No.

Name of Legal Guardian ___ Address ___ City _

Name and relation of person in case of serious illness or death of Patient _____

William T. Donaldson

Street Address Belleair Village Trailer Court, A Street, Largo, Florida

Has Patient ever been admitted to a Mental Institution? State Institution Marcy, New York

If so, give name and date about a year 1946-47

Has any accident, disease, condition, environment, or method of living in your opinion contributed to or caused the Patient's mental condition? _____

Are any criminal charges pending against Patient? No If so, nature of charges _____

Tentative Diagnosis _____

/s/J. O. Norton ,M.D. Address Dunedin,FL

/s/Virgil D. Smith,M.D. Address Clearwater,FL

[976]

FLORIDA STATE HOSPITAL

Chattahoochee, Florida

ADMISSION SHEET

Name Mr. Kenneth Donaldson Date

Date Hosp. No. A-25738

Date Committed January 3, 1957

County Pinellas Date of Admission Jan. 15, 1957

Home Address Belleair Village Trailer Court

"A" Street, Largo, Florida

Birthplace Erie, Pennsylvania

Date of Birth: Day Mo. May Yr 1906 Age 50

Nearest Relative Mr. William T. Donaldson

father Address Belleair Village, "A" Street

Largo, Florida Guardian Address

Sex Male Race White Nationality American

Ht 5'81/2" Wt. 165 Occupation Painting and Carpentry

Religion Unknown Marital State D

Resident of Florida - About 4 years

War Service unknown Prev. Hospitalization

State Institution, Marcy, New York

Father's Name William T. Donaldson

Birthplace Kingston, New York

Mother's Maiden Name Marjorie K. Whitbeck

Birthplace Kingston, New York

Former or subsequent admissions, furloughs, escapes and discharges:

Escaped 12/17/57 Ret'd Escape: 12/18/57

Discharges FSH 7-31-71
(Competency)

General Staff Conference
Consensus of Opinion: Hold
April 6, 1962 : mek

General Staff Conference
Consensus of Opinion: Hold
January 9, 1964 /cb

Staff Meeting
July 30, 1971
Recommendation: Discharge with Competency
MJH/vgg

General Staff Conference
Consensus of Opinion: Recommended release on trial visit or out of state discharge
March 21, 1968 IH/cb

Commitment papers state: "He is incompetent by reason of paranoid schizophrenia, is now a resident of Pinellas County; that his incompentency is acute and chronic; particular hallucinations being auditory and visual; that his propensities are delusions; that his age is 50; that he does require mechanical restraint to prevent him from self-injury or violence to others; he is indigent and is eligible to be committed as such."

EXAMINING COMMITTEE: J. O. Norton, M. D., and Virgil D. Smith, M. D., and Wilmer James.

#2 Kenneth Donaldson A-25738 Admitted:1/14/57
Age: 50 History Given:1/22/57

COMMITMENT DATE: This 50 year old white male was admitted here 1-14-57 from Pinellas County, Florida

COMMITMENT PAPERS STATE: "He is incompetent by reason of PARANOID SCHIZOPHRENIA; is now a resident of Pinellas County; that his incompetency is acute and chronic; particular hallucinations being auditory and visual; that his propensities are delusions; that his age is 50; that he does require mechanical restraint to prevent him from self injury or violence to others; he is indigent and is eligible to be committed as such."

ADMISSION NOTE: Patient admitted 1-15-57; new patient, from the County seat of Clearwater, in the County of Pinellas. There are no Criminal Charges against the patient. Document stated that the apparent cause was PARANOID SCHIZOPHRENIA CHRONIC. His hallucinations are auditory and visual; his propensities are delusions.

Patient started the interview by stating that the whole situation was ridiculous. There was no reason for him to be here whatsoever. And one thing that I must promise that I give him no medicines, since he had been somewhat associated with the Christian Science movement he had decided that his new attitude toward life did not require any medicines.

Asked how he happened to come to the hospital, to tell me the details of it, the patient said he believed his father was behind it, he wasn't sure. Anyhow, he was arrested, and he doesn't know why. Then finally put in two days solitary in the Clearwater jail. Later he was taken out and put in the hospital section. He saw two doctors, one for one minute, and one for exactly three minutes, and then he came before the judge. He then repeated at this point that the whole thing was ridiculous. From hospital, he wrote to the Governor and to three newspapers, demanding that he have a court hearing. Finally the judge told him he could have an attorney, so he arranged to have the attorney come to the jail, and the judge and the attorney discussed his question, his probelm. However, the doctor's didn't show up. He wanted to have the doctors there on the stand so that they would be questioned. "I wrote an autobiography, you see, and some people, I suppose, would have been hurt by it. I was in the state hospital in New York State, had ECT. That was the Marcey State Hospital for three months in 1943. I received a full course of 20 ECT's. I didn't need them; it was all a misunderstanding. It happened on my job. At that time I was run down; I was a bit sick; had had some sort of a lapse. I don't know what it was, when they found me wandering around in the street. I signed the voluntary for ten day observation at the request of the judge.

#3 Kenneth Donaldson A-25738
History Continued

There was a little trouble there. Then two doctors signed the statement, and also my wife, that I should go to the hospital. I didn't blame my wife for that; she didn't know the difference. The treatment certainly didn't do me any good. It confused my memory, that's all."

"There is a certain gang who is spreading a lot of slander about me. They 'tend to put a fellow on the job with me, who works on me, and now it's got so when I get on these jobs and quit, it's only because they are up to it again." At this point I asked the patient who these people were who were probably scheming against him. He explained that a group of people, most of them Republicans, the rich Republicans. They knew of many of his ideas, and accepted and threw up their red caps for him and then when he was of no more value, they turned against him, and started this funny business. He said not all Republicans were against him, just a group of them. "I have written a number of letters which are of extreme interest, and I am sure you would appreciate, to Eisenhower, and several from the White and Head of the Labor Party, and Senator Russell, and several others, and I have given them many good ideas which they have accepted and used; ideas of the sort of thing they could use in the Foreign Policy and to deal with labor difficulties in the states."

At this point it should be pointed out that the patient had been living with his parents in Florida for only a short period of time. He had come down here to finish his autobiography; was from Philadelphia; that he really belonged in the North. He mentioned he had had a lot of difficulty with jobs again. That's what these were; he went on that he had had many jobs - painters, contractors, etc.

The patient was born in Erie, Pennsylvania, left there at the age of six where he attended high school in Syracuse. He went on from there for a year and a half at Syracuse University where he studies engineering. At the moment, he claims he is taking a home study course in law, but hasn't yet completed it. He left the University after a year and a half, said he didn't have any interest in it; was an honor student while in high school, but didn't have any interest when he got to college. Went home after college, and did nothing for about five years. "I wrote some, did a good deal of writing, stayed home for about four or five years."

Shortly after this period, the patient got married. It was during the depression. He moved to Auburn, New York and ran a service station for his father. At that time, his father had lost his job, and they opened this together.

#4 Kenneth Donaldson A-25738
History Continued

It was shortly after that, that the service station business folded up, and the patient tells the story of reasonably steady work for 13 and one half years. While married, he had three children. The oldest boy is in the Navy, the other two, one is a girl, aged 17, and one is 14. They live now with their mother and her new husband in Arizona. The patient was divorced 8 years ago. He said his wife simply decided she wanted to get rid of him, and there was nothing to it in Arizona, and all she had to do was go to Court. She also got the children. He paid for the children for two years after that divorce, but after that she freed him because she wanted to get it off her income tax. It made enough difference so that he didn't lose anything by it, and she looked after the three children. He has not seen them for some years.

At this time he was married, the patient was living in Arizona. He left there, went back East, Syracuse, fixed up the house and stayed home for a number of years. Then he took his family, that is, his mother and father, and they all went back to Arizona.

The patient states that it was about 7 years ago, while he was in Arizona, that the whole sky fell in, and got him into this trouble, and people began to use slander against him. That is when he started writing his autobiography in self defense.

Asked about religion, the patient is not directly associated with the Christian Science movement; has read a little about it, and has heard a little about it, but obviously knew nothing in particular. His opening remarks did not suggest an actual Christian Science orientation. The patient was asked further about his admission here. He said it was only that they believed that he had some sort of sex trouble. At this point the patient said that he felt that some one was putting poison in his food of some sort, and this also happens, he mentions, while in Los Angeles in about 1953. He went to the Psychiatrist about that and the judge, and etc. They had an investigation, he claims, and they checked his urine and found a trace of codine in it. He hadn't taken any codine, so he knew it was quit correct that people had been feeding him things to affect his sex organs. He mentioned, incidentally, at this point, that he was under a different name while in Los Angeles.

The patient gives nothing more in the way of a medical history that

#5 Kenneth Donaldson A-25738
History Continued

two operations for hernis, and scarlet fever at the age of 6, nothing else of any significance.

The patient in the beginning, was extremely resistent to interview, this had all been a gross mistake, but soon would up, and was very anxious to give a detailed story of it all. Very much of a mixed story of a man who apparently broke down while in University after a reasonable school adjustment. Stayed home for five years, finally got married, made a reasonable adjustment, except that during that stage he apparently had a severe nervous breakdown, Paranoid Schizophrenic Episode, was treated with ECT in a mental hospital in New York. Following discharge from there, he has moved about quite a lot, and it was only a few years later that he began to get the feeling that a lot of people were slandering him because of his, stealing his ideas that he had forwarded to Washington. He was apparently carried along with his concept for some number of years, and it has almost completely interrupted job progress. Each job he goes to he runs into the same trouble. At the same time, people are trying to put poisons in his food, etc.

Content: Numerous Paranoid delusions, no special obsessive compulsive traits noted.

Mood: Patient was serious and rather aggressive. There is perhaps some flattening, but nothing specific that could be noted in this respect.

Memory and Orientation: Appeared quite normal, and appeared quite normal, and appeared better than average intelligence.

SUMMARY:

Summary: The man at age of 46 apparently broke down somewhere in the age of adolescence and since that time has had treatment and made just a marginal adjustment. having difficulty in getting a job, and in job situations, and when he has gone, the picture is one of withdrawal and of Paranoid delusions, and there is possibility of auditory and visual hallucinations.

PHYSICAL EXAMINATION:

PHYSICAL AND NEUROLOGICAL EXAMINATION: Were completed. Blood pressure 120/180. All findings within normal limits. There is nothing to indicate CNS disturbance.

DIAGNOSIS:

22.3 SCHIZOPHRENIC REACTION, PARANOID TYPE 000-x24 300.3

CHA:MP

#6 Kenneth Donaldson A-25738
History Continued

LABORATORY FINDINGS:

Urinalysis: Color-Yellow, Cloudy; Spec. Gr.-1.024; pH-6.5; Albumin-Neg.; Sugar-Neg; Acetone-Neg; RBC/HPF-Rare; WBC/HEF-0-2; Misc.-Much Mucus; Epith. Cells-Few. 1-16-57

Examination of Feces: 1-16-57 Consistency-Formed; Ova and Parasites-None Found.

C.B.C. 1-17 Blood Sugar-107 Mg%; V.D.R.L.-Neg; Bromide-Neg.

3-23-57 Transferred to General Wards from G-6.

A. 193(a)

FLORIDA STATE HOSPITAL
WHITE MALE DEPARTMENT

August 16, 1957

Mr. H. M. Dean Supervisor
White Male Department

In conformity with General Memorandum No. 18, this is to request the assignment:

of Kenneth Donaldson, A-25738

Patient to do detail work

for me at Horticulture Dept. (without

privileges

I agree to give Mr. Kenneth Donaldson,

A-25738

Proper supervision and be responsible

for and return to Wards by: 5:00 p.m.

Signed /s/

Position

(with)
Approved for this work (without) ground privileges:

/s/ M.D. August 16, , 1957

Accepted and Assigned

August 16, , 1957

A. 193(ai)

NOTE:

Ground privileges cover west of waterworks road to Sawmill and North to U.S. #90 to a point South of Eastern Boundary of the Satsuma grove, then along said line North of opposite and rear premises of residence of F. D. Palsgraaf thence East to Sawmill North fence line.

A. 193(b)

FLORIDA STATE HOSPITAL
WHITE MALE DEPARTMENT

March 25, 1957

Mr. F. D. Bailey Supervisor
White Male Department

In conformity with General Memorandum No. 18, this is to request the assignment:

of Kenneth Donaldson A-25738

Patient to do Detail Work

for me at General Kitchen

I agree to give Mr. Kenneth Donaldson A-25738

Proper supervision and be responsible for and return to Wards by: 6:00 p.m.

Signed /s/

Position

Approved for work (with) (without) ground privileges:

M.D. 3-25-57

M.D. 3-25-57

Note: Ground Privileges cover west of waterworks road to Sawmill and North to U.S. #90, to a point directly South of Eastern Boundry of the Satsuma grove, then along said line North of opposite and rear premises of residence of F. D. Palsgraaf thence East to Sawmill North fence line.

A. 194

[985]

Mr. Kenneth Donaldson A-25738
GENERAL STAFF CONFERENCE
April 2, 1962

Doctor Gumanis:
SUMMARY:

This is the case of Kenneth Donaldson, white male, age 54, who was committed from Pinellas County on January 3, 1957, and was admitted to Florida State Hospital on January 15, 1957.

Past history indicates he was born in Erie, Pennsylvania on May 1, 1906, and had lived in Florida four years prior to his commitment. His occupation is listed as painter and carpenter. He was hospitalized at the Marcy State Hospital in New York during 1943 for a period of three months and received ECT. He was diagnosed Dementia Praecox, Paranoid Type.

On the Receiving Service in Florida State Hospital, he was delusional and paranoid, with defective insight and judgment. He believed that the Republicans had stolen many of his good ideas which he had recommended to the Foreign Police Association. He also felt that they had attempted to poison him by putting chemicals in his food.

On the General Wards he refuses his medication, and spends most of his time writing letters to various officials and demanding his transfer to a New Jersey or a Pennsylvania State Hospital. Otherwise, he is cooperative and has caused no other trouble.

He is being presented today for evaluation and further disposition of his case. He refuses to be furloughed to his parents and definitely does not answer any of their letters.

POST STAFF DICTATION:

The summary is as given. Kenneth Donaldson has been ill for the last fifteen years. He was hospitalized in the Marcy State Hospital in New York during 1943 for a period of three months and received ECT, and when released was on convalescent status. On admission here he was still delusional and paranoid, insight and judgment defective, expressed ideas of reference and other delusions. He spends most of his time writing letters to various officials, and I believe he enjoys doing this. The writer believes patient is still psychotic and should remain in the hospital.

MR. CUNNINGHAM:

I believe this patient still has a paranoid psychosis and should remain here.

DOCTOR OJEDA:

I agree with the examiner. I am of the opinion that efforts should be made in order to treat this patient with some intensive treatment and medication.

DOCTOR FERNANDEZ:

I agree.

DOCTOR ERDAG.

I agree that this patient needs treatment, although he refuses it. He should remain here.

[986]

Re: Mr. Kenneth Donaldson A-25738
GENERAL STAFF CONFERENCE
January 9, 1964

Doctor Gumanis:
SUMMARY

This is the case of Kenneth Donaldson, white male, aged 55, who was committed from Pinellas County on January 3, 1957, and was admitted to the Florida State Hospital on January 15, 1957.

The past history indicates that he was born in Erie, Pennsylvania, on May 1, 1906, and had lived in Florida four years prior to his commitment. His occupation is listed as a painter and carpenter. He was hospitalized at the Marcy State Hospital in New York during 1943 for a period of three months and received electroshock treatments. He was diagnosed Dementia Praecox, Paranoid Type.

On the Receiving Service of the Florida State Hospital he was delusional and paranoid, with defective insight and judgment. He believed that the Republicans had stolen many of his good ideas which he had recommended to the Foreign Police Association. He also felt that they had attempted to poison him by putting chemicals in his food.

On the General Wards this past year he has shown no particular changes. Basically he is still delusional with ideas of reference. He now has Representative Stallings from Duval County representing him.

He is being presented today for evaluation and further disposition of his case. He refuses to be furloughed to his parents, and definitely does not answer any of their letters.

Post Staff Dictation:

This patient has been hospitalized here since 1957. His past history reveals that he was hospitalized for a period of three months at the Marcy State Hospital in New York, and received electroconvulsive treatment. After that he was placed on convalesence care in the care of his wife. Since his admission here he has spent most of his time writing letters to various officials explaining to them about his hospitalization. He definitely is still paranoid. He has ideas of reference against his parents, with whom he refuses to correspond or hear from the doctor about their correspondence. Since his last presentation, I do not see any change in this patient. I believe he should remain here. We have tried in the past to furlough him to his parents, but he definitely refuses this. I know even if he is released to his parents he will require supervision. I don't think he is mentally competent at this time to be released. Diagnosis is the same, Schizophrenic Reaction, Paranoid Type.

Doctor Hanenson:

This is a case of paranoia, who has been hospitalized in the past. This afternoon he is very hostile. He shows evasiveness. Every question is answered, "This is a long story". The patient is still very

sick mentally, and I do not believe that he is ready to be released, even on a Trial Visit basis because he will never accept any supervision. He is incompetent and I diagnosis him as a Paranoia State. I believe he should remain in the Hospital.

Mr. Davis:

I think he is a paranoia and has been since he has been in this Institution. I think he should remain in the Hospital.

Mr. Cunningham:

I agree that he should remain here.

Doctor Chacon:

Basically he has shown no insight. He is paranoid and incompetent and should remain in the Hospital.

Doctor Dunin:

I agree with the examiner.

Doctor Erdag:

I also agree that the patient does not show any change in his mental condition. He still remains paranoid. He uses denial mechanisms as a defense and I also believe he is not ready for a Trial Visit.

Doctor Ravenet:

I agree.

Doctor Rich:

I agree

Doctor O'Connor:

No question about me agreeing. The consensus of opinion is to hold him in the Hospital; that he is incompetent and considered to be dangerous to others; and that he should be held in the Hospital until further improvement.

CONSENSUS OF OPINION:

HOLD -- He is incompetent and considered to be dangerous to others and should be held in the Hospital until further improvement.

/cb

GENERAL STAFF CONFERENCE
Re: Mr. Kenneth Donaldson, A-25738
March 21, 1968

The above named patient was presented before the General Staff Conference this date. The following doctors were present: Doctors Hanenson, Dunin, Lopez, Ponsdomenech, Cespedes, Rich and Gumanis.

Diagnosis: Schizophrenic Reaction, Paranoid Type.

CONSENSUS OF OPINION: RECOMMENDED RELEASE ON TRIAL VISIT OR OUT OF STATE DISCHARGE.

/vgm

[989]

Staff Meeting
Re: Mr. Kenneth Donaldson A-25738
July 30, 1971

Doctor Hirshberg:

Mr. Kenneth Donaldson is a 65 years old divorced man who was admitted to Florida State Hospital on January 15, 1957, on a commitment dated January 3, 1957. He was admitted under Section 394.22, Florida Statutes, following adjudication of mental incompetency.

He has a history of hospitalization in the Marcy State Hospital in New York in 1943 when he was approximately 37 years of age. He had electroshock treatment at that time. Subsequently he became divorced, had lived in Arizona for a while, and then came to Florida with his parents. He tended to think that people were slandering him, stealing his ideas, or threatening to put poison in his food, and as his adjustment at home evidently deteriorated his father applied for his hospitalization.

When I met with him on July 26, 1971, we were in the supervisor's office of Department C. He appeared to have the physical vigor and health appropriate to his age. He was pleasant and he spoke with me in a direct, logical and coherent fashion. We discussed his hospitalization, and he talked about this in a reasonable

way with many suitable and appropriate comments which indicated an intellectual competency with somewhat complex facts. He said that if he were to leave the hospital, he would be able to take a bus to Tallahassee and register at a hotel and await the appearance in Court which is to be scheduled sometime in August. On the basis of his demonstrated assurance that he could look after himself if he were to leave the hospital, that his thinking was clear and logical, that he had a realistic appreciation that the transition from the hospital to community life would be challenging, that there was no defect of his intellect, that he had a successful adjustment in managing ground privileges, was not in need of medication, it was my impression that as long as he did not wish further treatment, that he should be discharge. When I told him this, he asked to reach his attorney, and he then placed a long distance call to New York City to his attorney to inform him of my wish to bring him to Staff because of my opinion that he could be discharged. The next day, we learned that his attorney had instructed him not to go to staff.

It was my belief that the patient should not remain in the hospital in any prolonged way, if the need for hospitalization had terminated, merely because his attorney told him to. On the other hand, in view of this man's long-standing hospitalization and the challenge he would face in adjusting if he were to leave the hospital against his will, I was willing to give him time to

think over the prospects of leaving at this time. I then asked Doctor Jesus S. Rodriguez and Doctor Octavio Penell, the Florida State Hospital Clinical Director, to independently evaluate Mr. Donaldson on the question of his readiness to leave the hospital. I have now received the extensive findings of these two psychiatrists, and they concur with my own. Accordingly, it is our decision that Mr. Donaldson be given a competency discharge from Florida State Hospital. I talked with Mr. Donaldson in the Suprevisor's Office of Department C at 1:00 p.m. today and he said he wanted to leave the hospital and would depart tomorrow for Tallahassee. He did not want after-care contact with any mental health agency whatever.

DOCTOR PINELL:

Concurred with Doctor Hirshberg.

DOCTOR RODRIGUEZ:

Concurred with Doctor Hirshberg.

RECOMMENDATION:

Discharge with competency.

MJH/mg/vgg

[1002]

Donaldson, Kenneth A-25738

PROGRESS NOTES

3-25-57: Patient appears to be old paranoid with hospitalization for 3 months, at the Marcy State Hospital of N.Y. Appears to be in remission at present time. Apparently refuses medication because he belongs to the Christian Science Group. Continue custodial care. Dr. Gumanis/hh

7-23-57: Patient writes continuously letters and states he will write a book about hospitals when he is released from F.S.H. Resides on Wd.#6, and works in general kitchen. Dr. Gumanis/hh

12-18-57: Patient was returned from escape while working the Horticulture Department. States he is tired of waiting for a release. No injuries except for small abrasion on lower extremities. To Wd.#8. Dr. Gumanis/hh

9-2-58: Patient is a 51 year old paranoid who again requested that he be released. Treated at Marcy Hospital of N.Y. with E.C.T. During interview overtalkative, delusional, well oriented in all spheres. States he is a native of Philadelphia and would like to obtain a position in the above city. Psychological examination ordered for our files. Dr. Gumanis/hh

12-11-58: Resides in Wd.#1, no work. Writing short stories complaining constantly about his N.Y. papers. States the attendants are delaying his papers, appears paranoid and delusional to writer, Continue custodial care. Psychological examination not satisfactory. Dr. Gumanis/hh

3-21-59: Patient today is complaining that certain friend in Tuscon Arizona is not receiving his letters. There are no changes in his mental condition he still is delusional and paranoid. Believes his letters to his daughter are not mailed, and he is not mentally ill, judgment and insight defective, continue custodial care. Dr. Gumanis/hh

4-23-59: Resides on Ward #1, no work. No changes in mental condition patient still appears delusional and paranoid to writer. Complaining that someone stole his short stories, continue custodial care. Dr. Gumanis/ep

5-22-59: Patient today asked that a registered letter be mailed to his sister in Arizona, he had a $1.00 enclosed. the matter was brought to Dr. O'Connor attention and it was decided that it be send by ordinary mail no changes in mental condition, refuses to take any type of medication, states he is not sick, judgment and insight grossly impaired. Dr. Gumanis/hh

7-30-60: Reveals no changes mentally, he is delusional paranoid, he still wants to be moved to a private hospital in New Jersey, he still refuses to write to his parents. This patient is still psychotic and requires further hospitalization. Dr. Gumanis:jwl

10/18/60 No changes, continue care on the wards. Dr. Gumanis/jwl/cb

4-17-61: Reveals no essential changes in his mental condition. He is delusional and paranoid. Persists he not a resident of Florida, Psychological examination ordered, also referred to Social Service. Dr. Gumanis/jwl

6-1-61: No changes mentally, he is still delusional, and his judgment is poor. Dr. Gumanis:jwl

[1003]

Donaldson, Kenneth, A-25738

PROGRESS NOTES

7-26-61: Pt. stated he would like to be transferred to New Jersey, because he was railroaded to F.S.H.. Belives that people poisoned his food with codine in the past, is also mad because he pays $75.00 mo. for maintainance and other pts. do not pay. Also states that he is mistreated because he does not work on the wards. The only solution he has is to be transferred to a private institution in New Jersey or have his 25 year old son furlough him to California. Later he states the third solution is to break away from this hospital, but he will not escape because it is against his priciples. In conclusion this patient has shown no changes since the last interview, he is basically delusional and paranoid. Dr. Gumanis: fn

8-30-61: Patient was interviewed today. He had a lengthy (5 pages) letter which was discussed in details. Well written at the beginning of it was becoming disorganized and at the end showed full paranoid content against masons, KKK etc and centering all of his ideation about the fact that he was a "hard-shelled yankee." Patient has absolutely no insight and believed that because he "ate well, sleep good, not violent to others," etc. should be released from the Hospital. He even denied being mentally ill in the past when he had to be Hospitalized in N.Y. and given a series of E.C.T. Possibility of taking medication was discussed but patient refused

and asked no to be "forced to him". He was explained that unless he was convinced of his being mentally ill would probably be of little benefit in his particular case. Possibility of out of state discharge was discussed (two daughters living in Arizona) and patient accepted it. Dr. Char: jwl

9-25-61: Mr. D. was seen today for the purpose of forming a group for "Group Therapy". Mr. D. Absolutely refused to participate on the grounds that there is nothing wrong with him. Dr. Char:jwl

1-6-62: Pt. stated there are three ways for him to get out of the Hospital. First, transfer to N.J. second, discharge from the Hospital on an out of state discharge. third, to escape. Was quite emphatic in that this was his last year in this institution. Son and daughter haven't answered letters about a T.V. and he doesn't want to go on T.V. to his parents, in Largo, Pa. Patient still hopes the Supreme Court will free him thru a Dr. friend in N.Y. I believe pt is still basically delusional but he is more calmed and collected than in the past.Continue care on the wards. Dr. Char/ga

3-13-62: Pt. is writing varios letters to officils. Psychological examination ordered. Dr. Gumanis/ga

4-3-62: Resides on ward #8, shows no particular changes mentally, he is still delusional and paranoid with impaired judgment. He has no other object in his life than his transfer to New Jersey State. Still persists he is a New Jersey resident

and refuses to submit to injustice-
Continue custodial care. Dr. Gumanis;ml

6-13-62: No improvement, patient is still delusional and paranoid and his judgment is poor, continue care on the wards.
Dr. Gumanis/jwl

7-11-62: Patient states that other patients call him a homosexual and call his family bad names. Asked for a privilege card, request denied. Dr. Gumanis/jwl

[1004]

Donaldson, Kenneth., A-25738

PROGRESS NOTES (CON'TD)

10-22-62: No improvement, states his condition has not changed, continue care on the wards. Dr. Gumanis/jwl

11-9-62: Patient resides on ward #8, shows no perticular changes in his mental condtion. He now asks to be released to a cousin of his who lives in Syracuse, N.Y.Dr. Gumanis/ml

12-28-62: Physically. Dr. Chacon/jwl

4-17-63: Patient is the same, he complains about various matters concerning mangment and shows no insight towards his mental sickness. He still refuses to write or see his relatives. Recently he wrote a letter to the U.S. Attorney Mr. Ashmore about his case. Dr. Gumanis/jwl

6-13-63: No changes mentally, his judgment is still defective and he requires care.
Dr. Gumanis/jwl

9-4-63: Patient was denied a petition of Habeas Corpus and he shows no improvement mentally. Dr. Gumanis/glm

9-24-63: No changes mentally, patient is still delusional and paranoid, his judgment is still defective and he does not realize he is mentally ill. Dr. Gumanis/jwl

12-13-63: Resides on Ward 8, is not working and has not received any medication. Basically he still is delusional towards his parents and he shows no insight towards his mental sickness. States he has never been mentally ill. This patient was hospitalized for three months during 1946 at the Marcy State Hospital of New York. Believes he was committed to this Hospital "because someone wanted him out of circulation." This patient, if he is released, will require supervision. States if he is released he will live in Syracuse, New York and finish the book he is writing. He also expects to finish law correspondence in law and also take the Courts all the people involved in his commitment. Psychological examination ordered. Dr. Gumanis:mmc

12-27-63: A letter was received from the patient's parents. When this was mentioned he ignored the matter and stated, " I do not want to hear about it". He still feels his parents performed the wrong thing by hospitalizing him at the Florida State Hospital. Dr. Gumanis/mmc

1-17-64: Patient is demanding. He called writer a liar when asked why he requested to be placed in Occupational Therapy. Apparently he wishes the use of the typewriter department. He became infuriated when this was mentioned and walked out of the office. Request denied. Dr. Gumanis:mmc

3-5-64 States he wishes to send $100 to his daughter who lives in Arizona to come

and escort him to a Half-a-Way House in Minnesota. Mentally he shows no change. He is still lacking judgment and there is no insight towards his mental sickness. Dr. Gumanis:mmc (After consultation with Dr. O'Connor it is decided that the money would not be sent until arrangements for patient's release are made.). Dr. Gumanis:mmc

PROGRESS NOTES:

Donaldson, Kenneth, A-25738

4-2-64: Patient today for the first time accepted to be furloughed to his parents. Wrote a letter to Dr. O'Connor explaining matters. Dr. O'Connor was also of the opinion that the only solution was a furlough to his parents. Was promised that he will be interviewed again. Dr. Gumanis:mmc

7-7-64: Resides on Ward 8. Shows no particular changes mentally. He is still delusional and his judgment is poor. States he will live in Syracuse, New York and receive Social Security of $101. A Mr. John Lembcke, a public accountant, wishes to sponsor him in New York, however, Dr. O'Connor does not agree with this plan. Dr. Gumanis:mmc

7-20-64: No changes in his mental condition. He is still basically delusional and does not believe he is mentally ill. Dr. Gumanis:mmc

11-27-64: Resides on ward seven, shows no particular changes mentally. An accountant from Binghampton; New York asked for his release. Dr. O'Connor does not agree with this plan. States he corresponded with President Johnson in the past, he also wrote him last month. Request for release to New York denied. Dr. Gumanis: jp.

1-14-65: Resides on ward seven, shows no changes mentally. He is now corresponding

with his parents. This patient will be considered for Staff again. Dr. Gumanis:jp

5-17-65: Mentally unchanged. Dr. Chacon:jp

5-19-65: Patient shows no changes mentally. Resides on ward 7. He still expresses delusions and paranoid ideas against certain persons, his judgment is poor and he has no insight towards his mental sickness. He is suspicious of the motives of others and is negativistic. States he has not received any medication and he corresponds with his parents at times when they have questions about his status. States he will have a new attorney and physician to come to examine him. Plans to go to Syracuse, New York and obtain a civilian job. Further expects to publish his book about his hospital experiences, but will not hurt anyone. His daughter who lives in Tuscon, Arizona would gladly have him, but he prefers to live in Syracuse, New York. Physically the past year he is well and he enjoys the food. Believes he has never been mentally ill and the E.C.T. he has received at the Mercy Hospital in New York is a mistake. He further states that the doctors that examined him in Pinellas County did not examine him physically or mentally and he found out about this three years later. Dr. Gumanis:jp

8-30-65: Physically no complaints. He states he feels physically well mentally he maintains the idea that he is all right now and doesn't belong here. Continue custodial care. Dr. Chacon:glm

-2-65: Patient states he will not discuss his case with writer. He was mad and refused to be interviewed. This patient continues to show no changes mentally. Dr. Gumanis:jp

-65: Patient was seen in conference with Dr. Rich for about one hour. He shows no changes in mental condition and is still delusional and paranoid on certain things and reveals no insight into mental illness. When oral medication was offered he refused to take medication claiming he is not mentally ill.
Dr. Gumanis:jp

PROGRESS NOTES

Kenneth Donaldson, A-25738

2-21-66 Patient received a legal brief from the Southern District of the United States Court of Appeals from California for his own case. After consultation with Doctor O'Connor and Doctor Rogers it was decided that this brief will be given to the patient. Mentally he shows no changes and believes he is not mentally ill.
Dr. Gumanis:jp

3-29-66 Resides on ward seven, shows no changes mentally. Patient is trying to obtain records of his past mental sickness from a Philadelphia General Hospital. Patient is still hostile and believes he will be released through the Courts.
Dr. Gumanis:jp

5-12-66 A Mr. Lembcke from New York State was allowed to visit the patient today. Writer believes that he is trying to make arrangements for his release with the consent of his parents. Dr. Gumanis:jp

5-18-66 Patient was seen during an interview about 2 letters to Dr. in New York and Mr. Stallings. Patient was again paranoid against Dr. O'Connor and stated that the case will be handled by Court in Jacksonville. He accused Dr. O'Connor of being a Mason and head of the local Klu Klux Klan. He shows no judgment in his conversation. When told that Mr. Lembcke had traveled to his home to obtain the written permission of his parents he

told writer he will not go to Staff. He will receive an Out of state discharge if the written permission of the parents is obtained and the patient passes staff. Dr. Gumanis:jp

6-28-66: Patient reveals no particular changes mentally. He refuses medication and has no insight towards his mental sickness. A son who lives in Hollywood California has written us a letter recently about his father's case. Dr. Gumanis:glm

7-12-66 Patient refuses to see his daughter who lives in Arizona and has not seen her father for the past twelve years. Mentally Mr. Donaldson shows no particular changes. When he was advised that his daughter will visit him on July 25, 1966, he stated "that his case is in Mr. Stalling's hands and he will not see her.". Dr. Gumanis: jp

7-25-66 Patient's daughter from Tuzon Arizona visited him today and he refused to see any one claiming that he advised his daughter not to write the hospital about his condition. Patient's daughter was a sad about situation and she left the hospital without seeing her father. Dr. Gumanis:jp

1-20-67 Resides on ward seven reveals no changes mentally. Patient was advised that his mother died and the only comment was that he was sorry, but she was 90 years old. When asked if he wishes to leave by receiving help from the Vocational Rehabilitation Service he stated that Mr. Stalling will have tc be present and be with him at Staff. Dr. Gumanis:jp

2-1-67 Patient continues to be delusional and has ideas that people are prosecuting him. There is no judgment in this patient, He now states he would like to be released to his son who lives in California and he has correspondence with him. If this patient is released complete supervision will be required by some responsible person. Dr. Gumanis:jp. Psychological examination ordered.

A. 202(a)

Kenneth Donaldson, A-25738

-16-67 Patient again wishes to file a petition and wishes to have it notarized. He was advised that the Superintendent will have to decide. Mentally he reveals no changes. Dr. Gumanis:jp

A. 202(b)

TRANSFER, PROGRESS, AND MEDICATION

Re: Mr. Kenneth Donaldson, A-25738

April 18, 1967

This 60 year old w/m was transferred from Dept. A to Dept. C as an exchange patient. Patient has been here since 1/15/57, and was diagnosed as Schizophrenic Reaction, Paranoid Type.

He is partially oriented as to time. He i. over talkative, over productive, stated there was no legitimate reason to be locked up for the past 10 years. Some ideas of reference centered mostly toward his previous examiner.

According to the record he was before the General Staff Conference on 4/6/62, at which time it was the consensus of opinion that he remain in the Hospital. He was presented again to General Staff Conference on 1/9/64, at which time it was also the consensus of opinion of the Staff that he remain in the Hospital.

DX: Schizophrenic Reaction, Paranoid Type.

RX: Thorazine 50 mg. tab. TID
IF ORAL MEDICATION IS REFUSED, TO BE GIVEN: Thorazine 50 mg. IM Q4H PRN

Physical survey was done by Doctor Sanguinetti. Review of system within normal limits with exception of external hemorrhage. Blood pressure 140/80. IH/pam

April 27, 1967
The above named patient was seen again, at which time it was noted that there were some spots on both sides of the nose andof the infraorbital region bilaterally. The Thorazine was temporarily discontinued and to be checked in a few days again.
IH/pam

May 1, 1967
Patient checked again and apparently the spots as mentioned in the progress note above have disappeared and his medication will be changed to Mellaril 50 mg. tab. TID, and Decavitamin 1 BID. This patient continues to talk about having filed a writ of habeas corpus and we discussed this matter with the patient.

IH/pam

May 11, 1967
The above named patient was seen by this examiner in a lengthy interview, at which time it was noted that he appears to be much quieter than he has been in the past. Apparently the hostility he has shown in the past is gradually subsiding. There is a possibility for a new psychological testing and the representation before the General Staff will be considered. His medication was discontinued on May the 4th, 1967. He resides on ward 10, building 41, and presently taking part actively in Occupational Therapy.
IH/pam

June 6, 1967
The above named patient was seen by this examiner in a lengthy interview, at which

time patient again made some remarks that were equalivalent to ideas of reference centered toward a previous examiner. This patient asked this examiner that he wants to be presented before the General Staff to gain a competency discharge, but at the present time patient does not have any concrete plans for the future. He will be seen again in a week to discuss this matter. He resides on ward 8.
IH/pam

PROGRESS NOTE

Re: Mr. Kenneth Donaldson, A-25738

February 27, 1968
The above named patient has been seen periodically by this examiner. There is apparently some residuals of hostility toward this Institution and toward a previous examiner still present. He stated to this examiner since he has been here in Dept. C he has not complained whatsoever and that he has been treated like a human being in every respect. He stated that his case will be up before the Supreme Court and he still believes that he has been held here illegally. He is taking active part in Occupational Therapy and resides on ward 8.

His main goal at the present time is to obtain a release from the Hospital.
IH/pam

March 12, 1968
The above named patient has been seen periodically at least once a week since his transfer from the Dept. A to Dept. C. There were times during the interviews the patient exhibited a number of paranoid delusions and ideas of reference mostly centered toward a previous examiner and the Hospital administration. There were other times during the interviews this patient appeared to be under satisfactory control, elaborating in detail his hospitalization in Chattahoochee. Since he has been at the Dept. C he was continuously amenable to general discipline, was no management problem whatsoever, always respectful in every way. A new psychological testing will be administered with the

possibility to be presented before the General Staff Conference on Thursday, March 21st.
IH/pam

March 20, 1968
The above named patient was in this examiner's office for the purpose to clarify the special interview he had on Monday, March 18th, 1968, in the office of this examiner.

He was asked a question whether he realizes that the interview was recorded verbatim on the recording machine. He was also listening when this examiner read the question and answer of the interview.

The patient stated he was aware that the interview was recorded and as far as he is concerned he had no objection whatsoever. He said he was very pleased to give all the answers to the best of his knowledge and ability.
IH/pam

June 12, 1968
The above named patient was presented before the General Staff on 3/21/68, at which time the consensus of opinion was that he could be released on a Trial Visit or on an out-of-state discharge. He has been seen periodically by this examiner, and patient is apparently waiting to be released from the Hospital, if and when arrangements will be completed for his release (please see correspondence.).
IH/pam

A. 202(c)(ii)

August 2, 1968
This patient has been seen again in a lengthly interview by this examiner at which time no essential changes noted as compared with note above.
IH/lrh

A. 203(a)

A-25738 Mr. Kenneth Donaldson

April 30, 1969
The above named patient has been seen on numerous occasions in this examiner's office and also visiting in Building 41 where patient's reside. I watched this patient very carefully in every respect and it was noted that this patient has been helping a great deal with the patient's who are unable to write to their relatives. He was helping them in that respect. Furthermore, this patient was constantly occupying himself with reading material and in Occupational Therapy painting a great deal. We discussed a great deal his long period of hospitalization here and at the present time it was the opinion of this examiner that this patient is most definitely in remission of his past psychotic symptoms and has been so for some time.

This patient approached this examiner on numerous occasions to be permitted to see Doctor C. A. Rich, the Clincial Director for an interview with him. This permission was granted by this examiner and approximately over an hour this examiner saw Dr. Rich immediately afterwards at which time we went over the record and the Staff notes of March 21, 1968 and Dr. Rich stated that the patient if and when permitted to be released on an out of state discharged he would not have to live in the same city of the same house. As long as he is available to consult with Mr. Lembske. Dr. Rich further stated that no further authorization from the father who is over 90 years of age would be required.
IH/sd

A. 203

[1006]

SUMMARY SHEET

Mr. Kenneth Donaldson, A-25738

1-18-57 Received smallpox vaccine.

2-1-57 Completed 1st course typhoid vaccine

NAME Mr. Kenneth Donaldson A-25738
DATE 1-15-57
Claims all a mistake that he was brought here. Has been in Florida since Aug writing his autobiography and father arranged to have him arrested. Has sent his autobiography to Saturday Evening Post since arriving here. Writing in self defense against members of the Republican party who used many of his ideas on Foreign policy and labor relations. They have been slandering him and getting him moved off jobs for last 7 - 8 years.
Marcey State Hospital 1943. 10 E C T 3 months. Has seen several psychiatrists after near misses with the law. Lived most of his life in Pennsylvania, but moved about a lot. Divorced 8 years ago after 13 years married life - 3 children now with mother in Arizona. Has high school education.
Paranoid delusions, hallucinations as above regarding Republicans - pretty stiff and found to influence his sex organs.
History withdrawal - very poor job adjustment. Appears to have had breakdown in late adolenscence and made marginal adjustment ever since.
DIAGNOSIS: Paranoid schizophrenia of about 35 years standing. CHA

A. 203(i)

1-29-57 Letter requesting permission ECT CHA
3-23-57 Long standing paranoid schizophranic. Had 20 ECT's about 10 years ago. Has continued paranoid - gets excited - paranoid delusions fixed. Permission for ECT has been received, but patient steadfastly refuses shock. I do not feel it will help him, except if necessary to quiet acute episode. Has recently presented writ of Habeas Corpus. Sits quietly in ward and refuses to socialize - refuses to work.
Continually claims he is quite sane. Feel he could do some work on the wards. Physical condition good. CHA:G

10-14-65 Received 1 c.c. flu vaccine/la

[1007]

PROGRESS NOTE

Re: Mr. Kenneth Donaldson, A-25738

August 8, 1967
The above named patient was seen in a lengthy interview at which time he stated that he has some plans to be released from the Hospital. A new psychological testing was done on 7/13/67. It is contemplated that he be brought before the General Staff on October 12, 1967. He is presently on Decavitamin 1 BID.
IH/pam

July 17, 1969
The above named patient who has been here in Department C has never shown any poor behavior. He was always amenable to general discipline, minds his own business and was also polite to the examiner, to the ward personnel and on numerous occasions helping elderly patients and any other patients especially who are unable to write and helping to write letters to their relatives. This patient has been under satisfactory control mentally and on numerous occasions when seen by this examiner in personal interviews he was elaborating in detail, detailing his hospitalization since admission here of January 15, 1957. He was never a management problem and very respectful in every way. He has been in Occupational Therapy and is taking this work very seriously. This examiner is trying a possibility for a release in the near future. The fact is that he was presented to Staff on March 21,

1968 but was recommended a Trial Visit however, no one was available to sign the papers in Florida and this patient was not interested to remain in Florida. The Staff agreed then on an out of state discharge if satisfactory arrangements could be made.
IH/sd

September 9, 1969
The above named patient has been seen periodically in personal interviews at least once a week patient has always been amendable to general discipline. He is taking part a great deal in Occupational Therapy, he paints a great deal, reads, and helps with patients who are unable to write, he helps them with correspondence. It was decided that this patient should be given outside privileges and he will reside on ward #7.
IH/vgg

October 20, 1970
Today in Pensacola paper appeared a statement about Kenneth Donaldson, who said he is not getting any treatment in this institution. The patient in the last years on several occasions has been offered Group Therapy and treatment and he always refused. He said his lawyer told him don't take any medication or go to Group Therapy. Numerous psychological test and psychiatric interviews have been given, however, his behavior is good. He only tries to create problems in the hospital by writing the newspapers. He observes the rules of the hospital. We don't give any medication. On different occasions he has been offered to go to staff, however, he gets upset and refuses to go. Today Dr. Machado, and the supervisor, Mr. Carmichael were present

in the interview, and again we offered Group Therapy and talking about his medication and he still said the lawyer advised him not to take any, however he was friendly. cooperative. He showed some paranoid ideation about the hospital policy mainly about the superintendents office. We made this progress note to show what we are trying to do with this patient.
J. S. Rodriguez, M. D./vgg

[1008]

PROGRESS NOTES
(cont.)

Re: Mr. Kenneth Donaldson A-25738

February 24, 1971:
This patient was interviewed today again because of Doctor Walls' suggestion and the fact that his attorney, Doctor Birnbaum, might come to visit this weekend, in connection with a reporter. However, he was advised that the only person who could give permission for the reporter to see him would be Doctor Rogers, the Director of the Division of Mental Health. This patient asked if we had made previous progress notes. He was presented to Staff the last time in 1968, and release on Trial Visit or out of state discharge was recommended. However, even a layman will find that this patient is a schizophrenic, paranoid type, and he enjoys just creating problems for the Hospital. This patient has been offered group therapy, chemotherapy, and other forms of therapy, and on numerous occasions proposed to be reviewed by the Staff, but always he says he needs to consult with his attorney, Doctor Birnbaum. Since I have been in charge of this patient, I have never talked with Doctor Birnbaum regarding his case. At the present time the only therapy is millieutherapy to supervise his eating and sleeping and give him adequate care. This patient, if any of his family or even his attorney, Doctor Birnbaum, wants to take him and give him adequate supervision, he could

be released. However, this Doctor does not have this kind of intention. This patient writes numerous letters everyday to different papers, magazines, and even has a typewriter to write these letters. His physical condition is perfectly good and I usually talk with this patient in the hall everyday. He has never been a violent patient, he never has any physical problems; just writing letters to various papers and complaining about this Institution. I talked with Doctor Walls and I will be willing to take any suggestions for future treatment of this patient.
J. S. Rodriguez, M. D./cb

March 4, 1971:
Doctor Walls talked with this patient and he accepted to take the psychological tests.
J. S. Rodriguez, M. D./cb

March 10, 1971:
At the present time this patient has outside privileges however, he just writes letters to lawyers in California, in New York, and trys to write different papers. His behavior is good. He is more or less friendly, however, shows a great deal of hostility to the hospital and our previous Superintendent, Doctor O'Connor. Also, this patient has appealed to the Supreme Court on previous occasions, and one time in the Supreme Court said the patient should be kept in hospital. In the last interview with Doctor Walls and the patient, he said he will take the chance to have a psychological test and to go to Staff again. This patient will be held at this time until we clear with Doctor Rogers and

Doctor Walls about his appearance in Federal Court.
J. S. Rodriguez, M. D./vgg

April 19, 1971:
Patient said he sued the hospital, Doctor Walls, Doctor O'Connor and Doctor Rogers and he has a hearing about the 18th or 22nd of this month it is not clear because the lawyer who handles his case is from New York. At the present time, patient is friendly, cooperative, however, he still shows paranoid delusions. Has been offered on numerous occasions to be presented to staff. Has also been offered Group Therapy, but all was refused and he said his lawyer prohibits him from entering any group therapy or do any psychological test. This patient is negativistic to any kind of treatment He is paranoid and delusional at the present time, however, his behavior is very good. He has outside privileges. He does not cause any

[1009]

PROGRESS NOTES
(cont.)

Re: Mr. Kenneth Donaldson A 25 738

behavior problems on the wards or on the hospital grounds. At the present time his pursue is to annoy the officials the hospital and creat problems to the hospital, because he says he has been here for no reason at all. He will wait for the decision of the court in Tallahassee after the lawyers talk at his hearing. Mr. Bevis was present in the interview and could be as a witness that he continued to refuse any kind of treatment.
J. S. Rodriguez, M. D./vcg

June 21, 1971
This patient was examined today and discussed with him about the letter he wrote to his lawyer because he says that a group of patients were agitating him. It was also discussed with the superintendent, Dr. Walls, about this patient. The patient said one of the employees in O.T. was annoying him a lot and for that reason, he quit going to O.T. Also he said that for the last three years that some patients in Building 41 tried to have homosexual relations with him. We offered to transfer him to another ward; however, he said he wanted to remain in Building 41. In the opinion of the examiner at this time, this patient has a flareup like today. We offered medication and he said

he needed to consult with his lawyer about that like he had always done. However, then later on he said he is not getting any treatment in this hospital contrary to what we offered at the present time. Dr. Walls was notified of this interview with the patient.
J. S. Rodriguez, M. D./jw

A. 206(a)

FLORIDA STATE HOSPITAL

CHATTACHOOCHEE, FLORIDA

Ward 7

1 August 1958

Social Service Office
Florida State Hospital

Gentlemen:

I have been locked up since 10 December 1956 as being of the "paranoid type and possibly dangerous to the people of the state of Florida." I have been held without psychiatric examination: and without or receiving treatment of any kind. I am not Ill in any way and have I herewith at anytime during any stay here. The hospital refuses to consider me for discharge.

As I am a native of and a declared citizen of Pennsylvania I would like to have you make arrangements for me to be transferred back to Pennsylvania.

Thank you.

Very truly yours,
Kenneth Donaldson

A. 206(b)

DATE 8-1-58

TO: Dr. J.B.O'Connor

FROM: V.S.Williamson

MEMORANDUM
Florida State Hospital
Dept: Medical WM
Dept. Social Service

Re: Kenneth Donaldson A-25738

Do you want to refer this patient to Social Service? I note that his file is full of letters to many people and this one is probably just another experession of his illness. I see no indication of his residence being Pennsylvania.
/s/ V.S. Williamson

8-4-58
Evidently he sent this to you by another patient. He writes everyone, especially all prominent people, about his "unlawfull incarceration." I don't believe any other state will accept him.

Thanks,
J. B. O'Connor

October 8, 1962

Re: Mrs. Olive Kennedy

TO WHOM IT MAY CONCERN:

Mrs. Olive Kennedy has asked me to make a statement regarding her capabilities as head of Helping Hands, Inc., and their services.

I met Mrs. Kennedy through Dr. Arthur Foote, the minister of Unity Church in St. Paul in April, 1958. I had numerous conversations with her about her interest and work in Helping Hands Association, together with more general discussions about the problems of the patients before and after their discharge from mental hospitals.

I saw Mrs. Kennedy at the headquarters of the Association at her residence, 3748 Park Avenue, Minneapolis. Several times during these discussions, ex-patients came to enlist her aid. On one occasion, I was able to be of assistance to her in getting one of the ex-patients admitted to General Hospital in Minneapolis. Thus, I was able to observe Mrs. Kennedy in her work as President of Helping Hands Association.

At all times, I was impressed with her warmth and understanding of the problems of the patients. She is a "good listener" (rarer than it sounds until one thinks of it), and first establishes and then responds intelligently to their needs in a selfless manner.

I would say that it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care that she offers through Helping Hands. She carries the responsibility personally for any patient she has volunteered to take into her care.

/s/

Sherman E. Nelson, Ph.D., Clinical Psychologist
Minneapolis Clinic of Psychiatry and Neurology

SEN/em

A. 207

[1045a]

June 6, 1963

Dr. W. D. Rogers
Superintendent
Florida State Hospital
Chattahoochee, Florida

Dear Dr. Rogers: In re: Kenneth Donaldson

We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him in as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters.

Enclosed is a copy of an October, 1962 letter from one of our Advisors, giving you an idea of our work. Mrs. Kennedy has rehabilitated well over a thousand over the years.

The usual rate per month for food, home, telephone, laundry and counseling is $85 per month, or $19.50 per week. This rate varies. We have carried a disabled vereran at $125 per month; we have had some without any pay because they had nothing. At this time, however, there would have to be payments to cover costs.

We would appreciate an early reply from you as to the age of this patient, your

opinion of his health, his qualifications for work -- special training, education, etc. We have to make a decision at the earliest possible moment.

Kindly answer via air mail.

Cooperatively yours,

/s/

Henry Cantwell
President

June 17, 1963

Re: Mr. Kenneth Donaldson A-25738

Mr. Henry Cantwell
President, Helping Hands, Inc.
3800 Columbus Avenue
Minneapolis 7, Minnesota

Dear Mr. Cantwell:

This acknowledges the receipt of your recent letter in regards to the above named patient, and we wish to advise that Mr. Kenneth Donaldson was committed to the Florida State Hospital from Pinellas County, Florida, on January 3, 1957, and was admitted to this Hospital on January 15, 1957. He has been here continuously since the above mentioned date.

The patient is a 55 years old, white male, and his parents live in Largo, Florida. They are the ones who are legally responsible for him, since the patient is considered incompetent mentally at the present time.

Should he be released from this Hospital, he will require very strict supervision, which he would not tolerate. Such a release would be to the parents. We see no prospects of his release to any third party at any time in the near future.

Yours very truly,

J. B. O'Connor, M. D.
Clinical Director

JG/rr/cb
JBO'c/rr/cb

[1047]

25 A St —
Belleair Village
Largo - Florida
18th June '63

Dr O'Connor -

Not feeling too well, so it has hindered my writing about Kenneth. We hear from Kenneth occasionally but I cannot read manual - but it is good to hear from him -

Would like a few lines from you as to his condition, physically & mental.

Mr Donaldson is ageing & not very active for his age 55 - His mind dwells on Kenneth as normal fathers do - he love and care & and hearts are heavy -

a few lines from you will be appreciated -
Please excuse this writing -
Respectfully
Mrs Wm Donaldson



June 25, 1963

Re: Mr. Kenneth Donaldson A-25738

Mrs. William Donaldson
Belleair Village
Largo, Florida

Dear Mrs. Donaldson:

This is in answer to your recent letter, and we wish to advise that Mr. Donaldson has shown no changes mentally.

His judgment is still defective, and he does not realize he is mentally ill. Otherwise, physically he is well, and he is up and about daily.

Yours very truly,

J. B. O'Connor, M. D.
Clinical Director

JO/eb

MALLORY E. HORNE
Speaker

BC .Y RUSS
Speaker Pro Tempore

LAMAR BLE JE
Chief Clerk

W. A. BALLENTINE
Sergeant at Arms

FLORIDA HOUSE OF REPRESENTATIVES

TALLAHASSEE

GEORGE B. STALLINGS, JR.
REPRESENTATIVE, DUVAL COUNTY
409 LAW EXCHANGE BUILDING
JACKSONVILLE 2, FLORIDA

December 9, 1963

COMMITTEES:
ELECTIONS, CHAIRMAN
JUDICIARY C
APPROPRIATIONS
CONSTITUTIONAL AMENDMENTS
WORKMEN'S COMPENSATION
LEGISLATIVE APPORTIONMENT

Florida State Hospital
Office of the Superintendent
Chattahoochee, Florida

Re: Kenneth Donaldson

Dear Sir:

I would like to make a trip over to the Florida State Hospital on Monday, the 23rd of December for the purpose of interviewing Kenneth Donaldson and also to meet with you and Doctor Rogers if this is possible.

Please advise me at your earliest opportunity if I might come over and meet with you gentlemen at about 9:00 o'clock in the morning of December 23rd.

When I was in Gainesville, I discussed the possibility of such a meeting with Doctor Rogers and he encouraged me to come over at my convenience and talk with some of these people.

Thanking you for an early reply, I remain

Sincerely yours,

Geo. B. Stallings, Jr.

George B. Stallings, Jr.

GBS,jr/sh

SUPERINTENDENT'S OFFICE
FLORIDA STATE HOSPITAL
RECEIVED
DEC 2 1963

MALLORY E. HORNE
Speaker

BY RUSS
Speaker Pro Tempore

LAMAR BI OE
Chief Cl..

W. A. BALLENTINE
Sergeant at Arms

FLORIDA HOUSE OF REPRESENTATIVES

TALLAHASSEE

GEORGE B. STALLINGS, JR.
REPRESENTATIVE, DUVAL COUNTY
409 LAW EXCHANGE BUILDING
JACKSONVILLE 2, FLORIDA

February 17, 1964

COMMITTEES:
ELECTIONS, CHAIRMAN
JUDICIARY C
APPROPRIATIONS
CONSTITUTIONAL AMENDMENTS
WORKMEN'S COMPENSATION
LEGISLATIVE APPORTIONMENT

Doctor J. B. O'Connor, Superintendent
Florida State Hospital
Chattahoochee, Florida

Re: Kenneth Donaldson, A-25738

Dear Doctor O'Connor:

This will confirm the appointment in your office at 9:00 o'clock, Saturday Morning, February 22, 1964, at which time I will be accompanied by Doctor Frank Calhoun. We will try to be there a few minutes ahead of time.

Thanking you for making the necessary arrangements, I remain

Sincerely yours,

Geo. B. Stallings, Jr.

George B. Stallings, Jr.

GBS,jr/sh

SUPERINTENDENT'S OFFICE
FLORIDA STATE HOSPITAL
RECEIVED
FEB 18 1964
AM PM

A. 214

[1055]

January 9, 1964

Re: Mr. Kenneth Donaldson, A-25738

Honorable George B. Stallings, Jr.
Representative, Duval County
409 Law Exchange Building
Jacksonville 2, Florida

Dear Mr. Stallings:

In keeping with your request that the current psychological evaluation of our patient, Mr. Kenneth Donaldson, be done by a particular psychologist, namely Mr. Sam Cunningham, since Mr. Donaldson refused to be examined by the Chief Psychologist of this Hospital, you are advised that the examination in question was done by Mr. Cunningham, subsequent to your recent visit here.

The results of this examination are reported to show that Mr. Donaldson continues to display a paranoid type of thinking disorder and continues to express beliefs that have been present for many years. One chief such belief is that some political groups, apparently high in office and influence, and apparently outside of the State of Florida, have for years resented his efforts to advise other individuals high in government, and have, therefore, plotted to prevent his contributing ideas to the government. These ideas are identical with those Mr. Donaldson expressed at the time of his admission to this Hospital.

The results of Mr. Cunningham's recent examination have also been reviewed by the Psychology Department. His findings have been concurred in, and the conclusion reached by that department was that the patient still displays the symptoms of a serious mental disorder, that this condition was present at the time of his admission to this Hospital, and that it has shown no significant change at the time of this most recent psychological examination.

You are also advised that Mr. Donaldson was presented at the General Staff Conference of this Hospital today, January 9, 1964. At that

A. 215

[1056]

time, his entire history, and also the current psychological and psychiatric evaluations, were reviewed, and Mr. Donaldson himself was interviewed at great length by the members of the Staff.

It was the unanimous opinion of the members of the Staff that Mr. Donaldson is still suffering from a very serious and chronic type of mental disorder, which is manifested chiefly by extremely poor insight and judgment, by marked hostility to all who, he believes, oppose him in any manner, and by fixed beliefs that he has been persecuted for many years by certain organizations, especially those of a political nature, and that these have brought pressure and influence to bear on nearly all others he has contacted, including the courts, the law enforcement authorities, and also the staff of this State Hospital, and caused these agencies to persecute Mr. Donaldson and to conspire together to deprive him of his liberties.

It was also the unanimous opinion of the Staff of this Hospital that this patient is mentally ill to the degree that he is mentally incompetent, and that he is incapable of attending to his affairs outside of an institution without constant interference with others by his demands and allegations against them, and even may present some degree of danger to others.

In conclusion, it was the unanimous opinion of the Staff that because of these findings the patient could not be recommended for release from this Hospital at this time, but the Staff, of course, would be quite willing to agree to his transfer to some other state hospital, provided such state would acknowledge him as a resident of that state.

If further information is desired in this case, please so advise, and such will be furnished at once upon receipt of your request.

Sincerely yours,

J. H. O'Connor, M. D.
Superintendent

JHO'C:da

527

BEST COPY AVAILABLE

A. 216

[1057]

N. Germano — Stated
This man himself
not to be well to want to
let involved with parents
like this patient who we
the Neuropsychiatrist
considered "dangerous"
Recommend Lanier
From Florida 538 7-6-64

Det Lecard
Supts Office

A. 216(a)

FLORIDA STATE HOSPITAL

Retd 4-2-64

N. Germano — Letter re "plaintiff" to plaintiff's dau re "plaintiff" dau re plaintiff's alleged threats to kill Governor Kennedy & Negroes in Florida & Negroes in general. Dau requested that plaintiff be committed to Florida State Hospital. Plaintiff is presently confined in Florida State Hospital pursuant to Court Order. Plaintiff could not be released from Florida State Hospital without Court Order. In my opinion 4-2-64 & Lanier

BEST COPY AVAILABLE

JOHN H. LEMBCKE
CERTIFIED PUBLIC ACCOUNTANT
338 PRESS BUILDING
BINGHAMTON, N. Y. 13901

July 3, 1964

J. B. O'Connor, M. D.
Superintendent, Florida State Hospital
Chattahoochee, Florida 32324

Dear Doctor O'Connor:

Kenneth Donaldson, a friend of mine, is in your hospital.

If I were to come down to your hospital; are there any conditions under which he would be released so that I could bring him back to New York State?

Any information as to what is required and how it would have to be arranged will be greatly appreciated.

Sincerely yours,

John H. Lembcke

John H. Lembcke

RECEIVED
CLINICAL DIRECTOR
FLORIDA STATE HOSPITAL

SUPERINTENDENT'S OFFICE
FLORIDA STATE HOSPITAL
RECEIVED
JUL 6 1964
AM 7,8,9,10,11,12,1,2,3,4 PM

[1959]

July 7, 1964

Re: Mr. Kenneth Donaldson A-25738

Mr. John H. Lembcke
Certified Public Accountant
338 Press Building
Binghamton, New York 13901

Dear Mr. Lembcke:

This acknowledges the receipt of your letter of July 3, 1964, concerning the above named patient, and we wish to advise that Mr. Donaldson has shown no particular changes mentally.

He has been hospitalized continuously since 1957 at the Florida State Hospital, and he was presented before the General Staff of this Hospital on two occasions, and it was the opinion of the Staff that he requires further hospitalization.

If Mr. Donaldson is released, he will require complete supervision because of his poor judgment. We do not recommend his discharge to New York. His parents are living in Largo, Florida, and they are considered his guardians.

It is hoped the above information will prove of help to you in your present interest in this case.

Yours very truly,

C. A. Rich, M. D.
Clinical Director

JO/cb

541

[1060]

JOHN H. LEMBCKE
CERTIFIED PUBLIC ACCOUNTANT
888 PRESS BUILDING
BINGHAMTON, N. Y. 13901

November 23, 1964

James B. O'Connor, M. D., Superintendent
Florida State Hospital
Chattahoochee, Florida 32324

Dear Dr. O'Connor:

Is it possible that Florida State Hospital would approve releasing Kenneth Donaldson under my supervision?

We are not related but are friends since 1927.

His parents know me.

I am deeply interested in the welfare of Kenneth Donaldson.

If there is further information needed before reaching a decision; I will gladly submit any information which is available.

Sincerely yours,

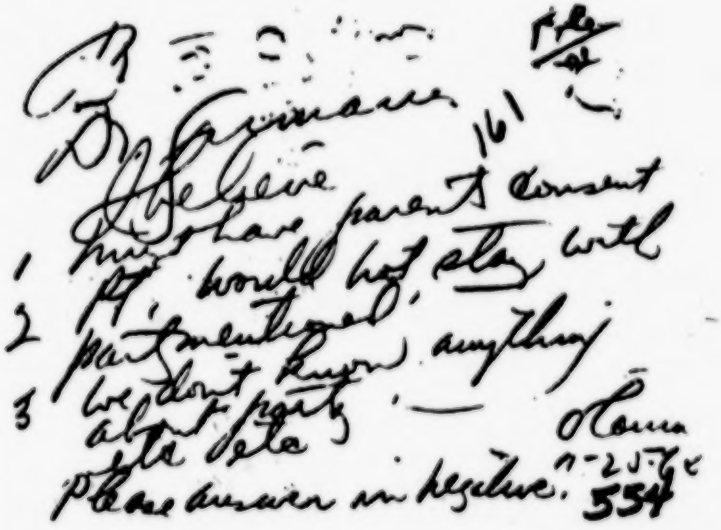
John H. Lembcke

John H. Lembcke

RECEIVED
CLINICAL DIRECTOR
FLORIDA STATE HOSPITAL
NOV 25 1964
A.M. 7-8-9-10-11-12-1-2-3-4-5-6 P.M.

RECEIVED
NOV 25 1964
A.M. 7-8-9-10-11-12-1-2-3-4-5-6 P.M.

[1061]



RECEIVED
CLINICAL DIRECTOR
FLORIDA STATE HOSPITAL
NOV 25 1964
A.M. 7-8-9-10-11-12-1-2-3-4-5-6 P.M.

BEST COPY AVAILABLE

A. 221

[1062]

November 27, 1964

Re: Mr. Kenneth Donaldson, A-25737

Mr. John H. Lambcke
Certified Public Accountant
338 Press Building
Binghamton, New York 13901

Dear Mr. Lambcke:

This acknowledges receipt of your letter of November 23, 1964, and we wish to advise that Mr. Donaldson has shown no improvement in his mental condition. Physically he is well, and he is up and about daily.

Mr. Donaldson was presented before the General Staff of this Hospital twice, during 1963 and during 1964, and it was the consensus of opinion of the staff members that he is not ready to leave the Hospital.

We are sorry to advise you again that Mr. Donaldson will require further hospitalization.

Yours very truly,

C. A. Rich, M. D.
Clinical Director

JG/mbg

BEST COPY AVAILABLE

55

A. 222

[1063]

PSYCHOLOGY DEPARTMENT
FLORIDA STATE HOSPITAL
CHATTAHOOCHEE, FLORIDA

August 9, 1965

Gregory and Towles
Attorneys-at-Law
Quincy, Florida 32351

Re: Donaldson, Kenneth
Age - 53

Dear Sirs:

Your letter inquiring about my psychological examination of the above mentioned man has been received.

Since I discussed my test results in a meeting with the hospital staff and Mr. George Stallings, I have no written report to send you. I can assure you, however, that the results of my examination were in complete accord with the diagnostic evaluation of the hospital staff. This man has the type of mental illness that is the most difficult for lay persons to detect. Even a psychologist or psychiatrist could be "fooled" by Mr. Donaldson unless certain types of psychological tests are included in the evaluation. Unless his condition has greatly improved since my examination, I still feel very strongly that Mr. Donaldson is ill, dangerous to society, and should remain hospitalized.

Sincerely yours,

F. J. Calhoun, Ph.D.

FJC:sc

[1064]

June 12, 1968

Re: Mr. Kenneth Donaldson, A-25738

Colonel H. R. Donaldson, Ret.
490 M Street, Southwest
Apartment 600
Washington, D. C. 20024

Dear Colonel Donaldson:

Your letter addressed to Florida State Hospital was forwarded to this Office for reply.

Your brother was presented before the General Staff on March 21, 1968, at which time it was recommended that he be released on Trial Visit or on an Out-of-State Discharge. The fact is, that your brother has a close frined, a Mr. John Lembcke, of Binghamton, New York, who would be willing to give him adequate supervision and if necessary to be checked periodically with a psychiatrist, if such should become necessary. Furthermore, it was the opinion of the Staff that Mr. Lembcke would be required to furnish a written authorization from his father, stating that he has no objection for him to come to the Hospital and take your brother to New York. At the present time we only have the statement from Mr. Lembcke that a room will be furnished your brother, and he would also be readily accessible to medical doctors to make use of their services. The only thing that was missing at the present time is a written authorization from your father that he has no objection

that Kenneth goes to New York with Mr. Lembcke. Your brother, Kenneth Donaldson, was presented before General Staff at the recommendation of his attending psychiatrist, which was accepted by the entire staff. It is also the impression of his attending psychiatrist that your brother is not capable of harming anyone.

We hope this answers all your questions. If you have any more, please do not hesitate to write and we will be glad to answer them.

Yours very truly,

C. A. Rich, M.D.
Clinical Director

IH/pam

[1065]

June 17, 1968

INTER-OFFICE COMMUNICATION TO:

J. B. O'Connor, M. D., Superintendent

FROM:

I. Hanenson, M. D., Department C

RE:

Mr. Kenneth Donaldson, A-25738

The above named patient has been under my supervision for over a year, and presently residing in Building 41, taking active part in Occupational Therapy.

He is well behaved in every respect, gives no trouble whatsoever, cooperates well, and has not written any letter with exception of the one he wrote to Doctor Rogers.

This case was thoroughly reviewed, and patient was presented before the General Staff on March 21, 1968, at which time the consensus of opinion was that he could be recommended to be released on a Trial Visit or on an out-of-state discharge. There is no way for him to be released on a Trial Visit in Florida because his father, who is over ninety years of age, would not be able to give him adequate supervision. However, an out-of-state discharge would be more feasible. This

patient has a friend, Mr. John H. Lembcke, who is a Certified Public Accountant, in Binghamton, New York, who would be willing to come for the patient and who would provide board, maintenance, etc., and if necessary psychiatric treatment for this patient while under Mr. Lembcke's supervision. Another requirement would be as mentioned by the undersigned and agreed upon by the Staff, that it will be required a written permission from patient's father, that he has no objection whatsoever for the release of his sone to Mr. John H. Lembcke, of Binghamton, New York.

IH/pam

[1066]

Department C
Florida State Hospital
Chattahoochee, Fla. 32324
4 June, 1968

William D. Rogers, Head
Florida Department of Mental Health
Chattahoochee

Dear Doctor Rogers:

It would seem likely that you remember me.

My lot has improved tremendously in the last year in Department C under Doctor Hanenson; and I am ready to be released out of state to my friend Mr. John H. Lembcke, of Binghamton, New York, except for one thing.

My freedom hinges on a technicality, namely, getting my guardian's authorization for my release to my friend. I am asking you, if you would please, to bypass this hospital ruling.

My father, William T. Donaldson, age 90, is my assumed guardian under Florida Statute. He has all along expressed his approval of my going to Mr. Lembcke's, but he is under premise to his lawyer not to sign any more papers. I have been unable to learn the name of his lawyer.

[1067]

I believe these further facts are also worthy of consideration in the matter: the guardianship now would not likely stand up in a courtof law; I have not made my permanent home with my father for 30-some years; I never intended to make my home in Florida; I have no other family members in Florida; and I have many friends up north anxious to help me at this time.

I would appreciate it, Doctor Rogers, if you would make it possible for me to be released at this time.

Sincerely yours,

Kenneth Donaldson

A. 227

[1068]

September 18, 1968

Dr. C. A. Rich, Clinical Director
Florida State Hospital
Chattahoochee, Florida 3234

Dear Dr. Rich:

I called Dr. Hanenson, the attending psychiatrist of my good friend, Kenneth Donaldson, on September 17, 1968 at 7:40 p.m. at which time I mentioned that I have written permission by his parents addressed to Dr. O'Connor, Superintendent, Florida State Hospital, Chattahoochee as follows: "We, Mr. and Mrs. William T. Donaldson, give our permission that our son, Kenneth Donaldson, be turned over to the care and supervision of John H. Lembcke."

Dr. Hanenson suggested that I write you, Dr. Rich, and enclose a photo copy of their notarized written permission.

You will note that the notarized written permission was signed and notarized May 14, 1966, which is soon after I visited Kenneth. It was a Saturday, and by the time I was driving north from them at Largo, Florida I realized that there apparently was little, if any, chance of my seeing anyone at your hospital until Monday at which time I had an appointment in Atlanta, Georgia, from which I could have been released but had not been released since I had no assurance of any action which would warrant my foregoing the appointment.

A. 227(a)

Since returning to Binghamton in May, 1966 my work has kept me busy and, further, I was made aware that Kenneth was exploring other ways to attain his release.

I also have made inquiries regarding such a matter since responsibility has never been taken lightly by me.

Since other means of securing Kenneth's release have not resulted in his release; and since it will be possible for me to follow through in seeing to it that Kenneth is taken care of and supervised; I am at this time submitting a photo copy of his parents' notarized written permission with a request that you kindly take whatever steps you feel necessary preliminary to releasing Kenneth to me.

When you have taken those steps, kindly notify me as to on or after what date you are willing to release Kenneth to me. I will do anything within my power to come for Kenneth on your stated date.

I will be watching my mail to hear from you.

Sincerely,

/s/

John H. Lembcke

Belleair Village Motel
Trailer Court A
Largo, Florida
May 14, 1966

Dr. O'Connor, Superintendent
Florida State Hospital
Chattahoochee, Florida

Dear Dr. O'Connor:

We, Mr. and Mrs. William T. Donaldson, give our permission that our son, Kenneth Donaldson, be turned over to the care and supervision of John H. Lembcke.

Sincerely yours,

William T. Donaldson
William T. Donaldson

Marjorie K. Donaldson
Marjorie K. Donaldson

Notarized:

State of Florida
County of Pinellas

Before me personally appeared William T. Donaldson and Marjorie K. Donaldson, his wife, to me well known and known to me to be the persons described in and who executed the foregoing instrument, and acknowledged to and before me that they executed said instrument for the purposes therein expressed.

WITNESS my hand and official seal, this fourteenth day of May, A.D. 1966.

CLINICAL DIRECTOR
FLORIDA STATE HOSPITAL
SEP 20 1968
A.M. 7-8-9-10-11-12-1-2-3-4-5-6 P.M.

Notary Public
State of Florida at Large

Notary Public, State of Florida at Large
My Commission Expires Aug. 29, 1969
Bonded by American Surety Co. of N. Y.

771

September 24, 1968

Re: Mr. Kenneth Donaldson A-25738

Mr. John H. Lembcke
Certified Public Accountant
338 Press Building
Binghamton, New York 13901

Dear Mr. Lembcke:

This is to acknowledge the receipt of your letter of September 18, 1968.

I am sure that you are aware that Kenneth Donaldson has been mentally ill for many years, and still expresses delusional thinking. It would not be fair to you or to him to release him from the Hospital at this time without adequate planning. From your letter, it is my understanding that you have not seen him since 1966. I do not recommend you taking him out of the Hospital until you become more acquainted with his case at the present time.

If you would like, you may visit the Hospital and discuss his case with me or with Doctor Hanenson, so that we can understand more fully exactly what your plans for him will be.

It will also be necessary for us to have authorization from his nearest relatives written more recently than 1966.

Yours very truly,

C. A. Rich, M. D.
Clinical Director

CAR/cb

775

[990]

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-25738
Date Examined: 9-19-58
Referred by: Dr. Guimanis
Age: 50
Educ: 1 1/2 years Syracuse Univ.

SUMMARY AND CONCLUSIONS:

Psychological evaluation reveals that this man's thinking is essentially paranoid. He has many rather poorly systematized delusions. He believes that people are continually talking about him not only telling things that are not true but telling obscene stories about him. The Rorschach record includes associations which point up some homosexual tendencies which is in agreement with the MMPI in showing a strong feminine orientation. Also it is noted that the paranoia and the psychopathic deviant are significantly beyong the normal range on the MMPI profile. The test record suggests that this patient is actively psychotic suffering from a paranoid psychosis which is probably schizophrenic in nature.

TESTS:

Rorschach

-A-Person

ATTITUDE AND PSYCHOLOGICAL CHARACTERISTICS:

On entering the examination room the patient stated in forthright manner that he did not appreciate the treatment he had received since being here. He does not believe that it was necessary for him to come here and he believes that since he has been here he has been discriminated against because he wrote a letter to the Supreme Court and because he is a Yankee. Mr. Donaldson maintains that certain persons he did not identify in Pennsylvania tried to blackmail him over the fact that he had had a previous mental hospitalization. He says that he wrote a book about this blackmail and sent it to the Saturday Evening Post. Several days later he was picked up by the authorities without explanation and briefly interviewed by some physicians who walked through the jail. He is very insistant that he be released from the hospital.

JCD:sb

[991]

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-25738
Date Examined: 7-28-60
Referred By: Dr. Gumanis
Age: 52
Educ: 1 1/2 years Syracuse Univ.

SUMMARY AND CONCLUSIONS:

This patient was originally tested on 9-18-58, at which time it was felt that his thinking was paranoid.

The present testing shows no significant change from the earlier findings. While many of his responses tend to be of good form quality, some of the content is bizarre and reflects a deteriorated logic.

Delusional content continues to be in evidence, essentially as described at the time of the previous tests with the exception that in 1958 certain unidentified persons in Pennsylvania were responsible for the nasty stories being told on him. Now he alleges that a certain senator from Arizona is responsible.

TESTS:

Rorschach

ATTITUDE AND PSYCHOLOGICAL CHARACTERISTICS:

Mr. Donaldson stated that the person who did the previous psychological examination on him was either incompetent or dishonest. He based the statement on being told that the report stated he experienced hallucinations. Actually, the only reference to hallucinations was on his committment papers. Mr. Donaldson again told about the book he has written, the deplorable treatment he has received, and the way people have talked about him everywhere he has been.

JCD/fd

[992]

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-25738
Date Examined: 6-1-61
Referred By: Dr. Guimanis
Age: 53
Educ: 1 1/2 yrs. college

SUMMARY AND CONCLUSIONS:

This patient has been tested on two previous occasions. He was first seen on 9-18-58, at which time it was felt that his thinking was paranoid. He was next seen on 7-28-60, and the testing at that time showed "no significant change from the earlier testing."

Present test data fail to show any undue disturbances of association or visual-motor incoordination. His drawings of persons are sketchy and noncontributory. His Rorschach responses are generally of acceptable form quality but some of their content tends to be bizarre. The overall impression gleaned from this test is that he is an emotionally volatile and overly suspicious type individual who is currently rather depressed. It is possible that he would show more deviant test results were he not so guarded and so familiar with the tests.

The impression one receives regarding the subject's mental status is more definite when clinical observation alone is used

to evaluate him. He tells a long and rather involved account of how certain unidentified persons have supposedly harrassed him for years. These persons have, according to him, continued this up to the present and he has written a book concerning this. He has also taken notes regarding observations made during his hospitalization, and has written these in some type of "code" unfamiliar to this examiner and evidently none too well known by the patient himself. He was asked to read some of this "code" and was only able to decipher a few words within several minutes. It seems that whatever was written somehow concerned "toilet paper". When judged in the light of a combination of behavior, current beliefs, and test results, this examiner feels that the patient remains incompetent.

TESTS:

Rorschach

Word Association Test

Draw-a-Person

Bender Gestalt

TAT

ATTITUDE AND PSYCHOLOGICAL CHARACTERISTICS:

The patient was oriented and reasonably alert. He denied hallucinations. He discussed the results of prior testing

done here and it was obvious that he has seen copies of at least the results of 7-28-60. He was firm in his conviction that he has not been treated fairly by Mr. Davis or Dr. Gumanis.

SC:fd

[993]

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-25738
Date examined: 4-3-62
Referred by: Dr. Gumanis
Age: 53
Educ: 1 1/2 yrs. college

SUMMARY AND CONCLUSIONS:

This patient has been seen on three previous occasions, the latest of which was on 6-1-61. He has been found to be emotionally volatile, overly suspicious, depressed, and paranoid.

The subject stated that he did not wish to take any tests at this time and that he, therefore, would not do so. He was polite but firm in refusing to re-consider this action. He was willing to talk, however, and expressed the same beliefs that he has maintained for approximately the past 10 years. These concern the "slander and blackmail" that he has been subjected to by "certain elements within the Republican Party:. He no longer writes his observations "in code" but did have a small notebook that he allowed this examiner to read. This noted the "logic" behind why he is considered paranoid and also contained an account of alleged mis-treatment of patients. He also wrote of various homosexual acts that he claims have occurred here.

SC:fd

[994]

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-25738
Date examined: 12-16-63
Referred by: Dr. Gumanis
Age: 55
Educ: 1 1/2 years College

SUMMARY AND CONCLUSIONS:

This patient refused to come in for interview. According to the Psychiatric Aide who talked with him, the patient stated that the Examiner is a liar, and he did not want to see him.

The patient has been evaluated on four previous occasions, twice by the writer and twice by another Psychologist. On each occasion he gave strong evidence or paranoid thinking and expressed ideas that he was being victimized by untruths.

JCD:fhp

[995]

PSYCHOLOGICAL EXAMINATION V

Kenneth Donaldson, A-25738
Date examined: 1-2-64
Referred by: Dr. Gumanis
Age: 55
Educ: 1 1/2 years College

SUMMARY AND CONCLUSIONS:

The patient's current test results, current behavior, and current beliefs continue to reflect a paranoid type thinking disorder. He remains overly suspicious of the motives of others, unduly negativistic and emotionally volatile. He refuses to believe that his hospitalization was necessary and writes "My anger has come about from the manner in which I was railroaded here and held all these years without requiring or receiving any treatment from any doctor." He further writes "to complicate my difficulties in the hospital, certain patients and employees carried on a campaign of villification and hard-timing of me for five years." He also writes that a particular congressman from New Jersey "filed a list of six of them with the United States Department of Justice. The fact that the filing almost stopped the hard-timing served my purposes as far as my stay here is concernted." He states that the patient and employees responsible for his difficulties were carrying out the instructions of the same political group that has harrassed him for years. He plans to bring all of

this "into the open" when the book that he has written is published.

TESTS: Rorschach

Word Association Test

Sentence Completion

Self Description

ATTITUDE AND CHARACTERISTICS:

The subject was oriented and reasonably alert but only passively cooperative. Hallucinations were denied. He claimed that arrangements are being made for him to go to a half-way house in the North.

SC:fhp

[996]

PSYCHOLOGICAL REPORT

Kenneth Donaldson, A-25738
Date: 1-6-64
To: Dr. O'Conner
Age: 55
Educ: 1 1/2 years College

A review of the record indicates that Mr. Donaldson initially underwent psychological testing in this hospital on 9-19-58. He subsequently has been evaluated by psychologists four times, 7-28-60, 6-1-61, 4-3-62, and 1-2-64. On one of these occasions, 4-3-62, he refused to take any psychological tests. On 12-16-63 he refused an appointment for psychological examination on the grounds that he considered the psychologist a liar and did not want to see him.

The first two psychological examinations were conducted by the writer. The impression gained both from statistical test date and from statements he made concerning discrimination against himself by persons both here and in Pennsylvania, was that he suffered from a psychosis. At the time of the second examination Mr. Donaldson stated that the person who did the previous psychological examination was either incompetent or dishonest. It is obvious that this attitude toward the psychologist still prevails even though he attributed the dishonesty to a statement concerning hallucinations which was in fact not reported by the psychologist but it was said to appear on his commitment papers.

Subsequently he has been evaluated on four occasions by another psychologist. Each time celusional and sometimes bizarre material has been elicited. In view of the fact that the patient has continued to maintain that his statements have not been accurately reported, he was asked to express himself in writing. The statements contained there, which are now on file with other psychological data, and are reported in the most recent psychological examination, are suggestive of serious mental disorder.

The patient's test record as well as his attitude and expressed ideas lead to the opinoin that the patient was suffering from paranoid ideas on his admission to this hospital and that his thinking has shown no significant change to the date of the last psychological examination on 1-2-64.

Julian C. Davis
Chief Psychologist

[997]

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson: A-25738
Date examined: 3-4-66
Referred by: Dr. O'Conner
Educ: 1 1/2 years Syracuse University

SUMMARY AND CONCLUSIONS:

Mr. Donaldson was seen in the company of Doctor Fredericson in whose office the interview took place. Mr. Donaldson walked in quickly, acknowledged the introduction to Doctor Fredericson and in response to the question "How are you?" stated that he was exactly as he has always been.

He declined to sit down and as he walked about the room made an emphatic statement that he did not plan to be examined again. "If you want to know the reasons for my refusal consult my attorney." In response to the question as to the name of his present attorney he said, "Mr. George Stallings." He then left the room.

JCD:fhp

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-35738
Date Examined: 7-13-67
Referred by: Dr. Hanenson
Age: 59
Educ: 2 years college

SUMMARY AND CONCLUSIONS:

This patient has been tested on numerous previous occasions. His degree of cooperation has varied markedly. His behavior, his written and spoken beliefs, and the test results have led to the conclusion that he was incompetent.

Current test results and behavioral observations indicate that he remains incompetent. The lack of any real change in his thinking over a considerable period of years is, in fact, the characteristic most easily noted. His condition is such that he cannot be considered capable of adjusting without aid and supervision, but he claims that he is willing to be released on a trial visit status and names a friend as one who would accept him under these conditions.

TESTS:

Rorschach

Word Association

Draw-a-Person

SC:ejy

PSYCHOLOGICAL EXAMINATION

Kenneth Donaldson, A-35738
Date examined: 3-19-68
Referred by: Dr. Hanenson
Age: 59
Educ: 2 years college

SUMMARY AND CONCLUSIONS:

This pateint has been seen and tested on numerous previous occasions. His behavoir, his written and spoken beliefs, and his test data have, when combined, led to the conclusion that he has been incompetent.

Current test and interview results reflect the first changes in his thinking that have been noted since he was first seen. There are no basic alterations in his disorder but he does appear to have become more composed, less sure of his delusions, and generally more cooperative. It is felt that he cannot be considered fully competent but he is willing and anxious to be released to a friend whom he says is eager to take him on a Trial Visit.

TESTS: Rorschach

Self Description

ATTITUDE AND CHARACTERISTICS:

Mr. Donaldson was polite, oriented, alert, and cooperative. He stated that he has done considerably better since his transfer to Dept. "C". In fact, he did not express any complaint of his present stay here. This, in itself, is unusual.

SC:fhp

[1000]

PSYCHOLOGICAL REPORT

Kenneth Donaldson, A-25738
Date Examined: 2-6-70
Referred by: Dr. Rodriguez
Age: 61
Educ: 2 yrs. college
Type Admission: Regular

REASON FOR ADMISSION:

Incompetent because of paranoid schizophrenia.

ATTITUDE AND PSYCHOLOGICAL CHARACTERISTICS AT THE TIME OF INTERVIEW:

This patient has been evaluated on ten occasions by this service and at least on one occasion by a psychologist not associated with this hospital. As this patient was last evaluated three months ago, it is felt that he need not be seen for further psychological evaluation at the present time, for reasons that will become obvious. Instead, a summary will be presented of all the previous psychological evaluations:

9-19-58 - Rorschach, MMPI and DAP in accordance in that the patient is a paranoid individual.

7-28-60 - No change from earlier findings. Rorschach content indicates bizarre content and deteriorated logic.

6-1-61 - Considered to be emotionally volatile and oversuspicious. Shown some notes about the hospital, taken in a "code" that not even the patient could understand.

4-3-62 - Refused testing, but expressed some beliefs as before.

1-2-64 - Patient's test results, behavior, and beliefs continue to reflect a paranoid thinking disorder.

1-6-64 - Report on the patient summarizes above findings.

8-9-65 - Letter from Doctor F. J. Calhoun, psychologist who made an independent evaluation, agrees with the above findings.

3-4-66 - Patient refused testing and left the room.

7-13-67 - Test results and behavioral observations indicated the patient to still be incompetent.

3-19-68 - Some progress noted. No basic alterations in his disorder were seen, but appeared to be more composed, less sure of his delusions, and generally more cooperative. However, was not considered to be fully competent.

11-12-69 - Rorschach record renders a "classic paranoid protocol." Although the patient's thinking was considered to still be distorted, it was suggested that further change is unlikely. Some

plan to get him out of the hospital was recommended, as the patient has been in the hospital for a number of years.

SUMMARY:

It should be evident that the patient is suffering from a chronic paranoid disorder and that further progress is quite unlikely. The recommendation set forth on the report of 11-12-69 should be given consideration.

AVD:fhp

[1001]

PSYCHOLOGICAL REPORT

Kenneth Donaldson, A-25738
Date Examined: 3-27-70
Referred by: Dr. Rodriguez
Age: 61
Educ: 2 yrs. college
Type Admission: Regular

A comprehensive summary of the numerous psychological evaluations of this patient conducted at various times since 1958 is given in a report dated 2-6-70.

Presently, Mr. Donaldson is friendly, courteous, and seemed pleased to discuss the case he has now pending in the Supreme Court of the United States. He recognizes that the Court may not rule on his case but he and his attorney, who is also a psychiatrist, are hopeful that the case will be heard in the near future. Because of this court action, and his belief that it will be decided in his favor, he is not interested in leaving the hospital at this time on any basis other than with his full competency restored. He recently declined to have his case presented to the staff because his attending psychiatrist could not guarantee that he would be given a competency discharge.

Mr. Donaldson alleges in his suit that he was illegally committed, that he has never been mentally ill and therefore has been unjustifiably held in the hospital. Apparently a third point in which his attorney seems more interested than

he is the allegation that he is receiving no treatment in the hospital and therefore should be released.

The patient has steadfastly maintained essentially the same position on all major points regarding his hospitalization since he has been here. He now appears to be on good terms with this examiner which has not always been the case and now acknowledges that various specific members of the staff have tried to help him. Nonetheless he feels that he has been done an injustice and he has been held primarily because he has refused to acknowledge that he has ever been mentally ill.

In the event of his release he said he would draw slightly over $100 per month from Social Security and allowed to earn a slightly amount. He hopes to augment his income by writing on mental health topics.

In my opinion Mr. Donaldson has fixed delusional ideas, accepting more or less uncritically any information that supports his position and rejecting any that is contradictory. I do not believe that his ideas are dangerous to himself or others, therefore I do not think continued hospitalization is necessary.

JCD/fhp

[10]

Q What provisions were there for release without a competency certificate?

A The only other way they could get out would be on trial visit status.

Q Could you explain what was involved in the trial visit. To whom would a patient be released?

A Well a patient could be released on trial visit strickly by his own doctor, without any other doctor being involved. He would be released to his next of kin, or if not to his next of kin, to someone else with permision of the next of kin.

Q And this would be a non-competency release?

A Yes.

Q Were such releases permitted if the patient were going to go out of state?

A Yes. I don't recall clearly just how we did that, but I do know we had a method of releasing them out of state.

Q And while he was released he would still be an incompetent?

A Yes. He would still be under his original commitment.

394.21 Hospitalization of the mentally ill; involuntary.—

(1) AUTHORITY TO RECEIVE INVOLUNTARY PATIENTS.—The head of a hospital may receive therein for observation, diagnosis, care and treatment any individual, and in the case of a public hospital only such persons as qualify under §394.27, whose admission is applied for under any of the following procedures:

(a) Hospitalization on medical certification; nonjudicial procedure, shall apply only to private and county operated hospitals.

(b) Hospitalization on medical certification; emergency procedure, shall apply only to private and county operated hospitals.

(c) Hospitalization without endorsement or medical certification; emergency procedure, shall apply only to private and county operated hospitals.

(2) HOSPITALIZATION ON MEDICAL CERTIFICATION; NONJUDICIAL PROCEDURE.—

(a) Any individual may be admitted to a hospital upon

1. Written application to the hospital by a friend, relative, spouse, or guardian of the individual, a health or public welfare officer, or the head of any institution in which such individual may be, and

2. Certification by two licensed practicing physicians of good professional standing, each of whom shall be a graduate of a school of medicine recognized by the American medical association, that they have examined the individual and that they are of the opinion that

A. He is mentally ill, and

B. Because of his illness is likely to injure himself or others if allowed to remain at liberty, or

C. Is in need of care or treatment in a mental hospital and because of his illness lacks sufficient insight or capacity to make responsible application therefor.

The certification by the said physicians may be made jointly or separately, and may be based on examination conducted jointly or separately, an individual with respect to whom such certification has been issued may not be admitted on the basis thereof at any time after the expiration of fifteen days after the date of examination. The head of the hospital admitting the individual shall forthwith make a report of such admission to the county judge of the county in which such hospital is situate.

(b) Such certification, if it states a belief that the individual is likely to injure himself or others if allowed to remain at liberty, shall upon endorsement for such purpose by the county judge of the county in which the individual is resident or present, authorize any sheriff, deputy sheriff, or police officer to take the individual into custody and transport him to a hospital designated in the application.

(3) HOSPITALIZATION ON MEDICAL CERTIFICATION; EMERGENCY PROCEDURE.—

(a) Any individual may be admitted to a hospital upon

1. Written application to the hospital by any health or law enforcement officer or any other person stating his belief that the individual is likely to cause injury to himself or others; if not immediately restrained, and the factual grounds for such belief, and

2. A certification by at least one licensed physician, as in this chapter qualified, that he has examined the individual and is of the opinion that the individual is mentally ill and because of his illness, is likely to injure himself or others if not immediately restrained.

An individual with respect to whom such a certificate has been issued may not be admitted on the basis thereof at any time after the expiration of three days after the date of examination. The head of the hospital admitting the individual shall forthwith make a report of such admission to the county judge of the county in which such hospital is situate.

(b) Such a certificate, upon endorsement for such purpose by the county judge of the county in which the individual is present, shall authorize any sheriff, deputy sheriff or police officer to take the individual into custody and transport him to a hospital as designated in the application.

(4) HOSPITALIZATION WITHOUT MEDICAL CERTIFICATION OR JUDICIAL ENDORSEMENT; EMERGENCY PROCEDURE.—Any sheriff, deputy sheriff or police officer who has reason to believe that

(a) An individual is mentally ill, and because of his illness, is likely to injure himself or others if allowed to remain at liberty pending examination and certification by a licensed physician, or

(b) An individual who has been certified under subsections (2) and (3) of this section likely to injure himself or others and therefore cannot be allowed to remain at liberty pending the judicial endorsement of the certificate as provided in those subsections may

take the individual into custody, apply to a hospital for his admission, and transport him thereto. The application for admission shall state the circumstances under which the individual was taken into custody and the reasons for the officer's belief. The head of the hospital admitting the individual shall forthwith make a report of such admission to the county judge of the county in which such hospital is situate.

(5) RIGHT TO RELEASE ON APPLICATION.—An involuntary patient who requests his release or whose release is requested in writing by his legal guardian, parent, spouse or adult next of kin, shall be released forthwith, except that

(a) If the patient by reason of his age, was admitted on the application of another person, his release prior to becoming twenty-one years of age, may be conditioned upon the consent of his parent or guardian, or

(b) If the head of the hospital within the hours of the ensuing business day, from the receipt of the request, files in the office of the county judge in the county where such patient is situate certification that in his opinion the release of the patient would be unsafe for the patient or others, release may be postponed for as long as the county judge determines to be necessary for the commencement of proceedings for judicial hospitalization, but in no event for more than five days; provided however, that in the event it becomes necessary that an involuntary patient in a state hospital be judicially committed after admission therein, as provided in this section, the costs incident to such commitment proceedings shall be borne by the county of the patient's residence.

(6) PAYMENT FOR CARE OF MENTALLY ILL.—Such reasonable charges and expenses as may be fixed by a hospital, or, in the case of a state hospital by the board of commissioners of state institutions of Florida, for the care, maintenance and treatment of a mentally ill person admitted to such hospital under the provisions of this section, shall be a lawful charge against the estate or property, real, tangible or intangible, of said mentally ill person in this state; that said charges and expenses may be lawfully paid from the estate of said mentally ill person by any authorized personal representative, parent or legal guardian of said mentally ill person thereafter appointed; provided, however, that the payment thereof, in advance, or otherwise, shall never be a prerequisite to the care, maintenance and treatment of any mentally ill person in a public

hospital under any circumstances whatsoever; that any suit or action instituted by the state or any political subdivision thereof for the recovery of such charges and expenses against said person or his duly authorized personal representative, parent or legal guardian, shall be brought by the state attorney of the judicial circuit in which said mentally ill person is resident or by the office of the attorney general of Florida or both such state attorney and office of the attorney general.

History.—§1, ch. 20504, 1941; am. §2, ch. 23157, 1946. Am. §2, ch. 29909, 1955.

391.22 Adjudication of persons mentally or physically incompetent; procedure.—

(1) PETITION FOR EXAMINATION OF PERSONS BELIEVED TO BE MENTALLY OR PHYSICALLY INCOMPETENT; PETITION.—Whenever any person within this state is believed to be incompetent by reason of mental illness, sickness, drunkenness, excessive use of drugs, insanity, or other mental or physical condition, so that he is incapable of caring for himself or managing his property, or is likely to dissipate or lose his property or become the victim of designing persons, or inflict harm on himself or others, application by written petition, under oath, may be made to the county judge of the county wherein the alleged incompetent resides or may be found, or, in the absence or disability of the county judge, to the judge of the circuit court of the county wherein such petition is filed, for a judicial inquiry as to the mental or physical condition, or both, of the alleged incompetent.

(2) WHO MAY FILE PETITION.—The petition may be filed by:

(a) The mother, father, brother, sister, husband, wife, child or next of kin of the alleged incompetent;

(b) Any three citizens of the state of Florida;

(c) The sheriff of the county where such alleged incompetent resides, if none of the persons named in paragraphs (a) and (b) file such petition;

(d) Any citizen of this state who requests the examination of himself, provided he presents a certificate of a physician authorized to practice medicine in this state, certifying that he believes such petitioner to be incompetent for any one or more of the reasons specified in subsection (1) of this section.

(e) In addition to the persons set forth and described in paragraphs (a)-(d), who may file a petition for the examination of a person believed to be incompetent as contemplated by this section, the superintendent of the state

prison farm in Union county, and the superintendent of the branch thereof in Marion county, are hereby authorized to file such a petition with respect to any person at said institution.

(3) NECESSARY ALLEGATIONS.—Every petition shall allege the name, approximate age, address, if known, and nature of the disability of such alleged incompetent, and shall name all the members of his family with their addresses, if known to petitioner, and shall pray for an examination of such alleged incompetent as provided by law and for an order adjudging such person to be incompetent.

(4) NOTICE; HEARING.—Whenever a petition is filed the county judge, or, in his absence or disability, a circuit judge, shall set a date for an immediate or a very early hearing on the petition. Reasonable notice shall then be given in writing to the alleged incompetent and to one or more members of his family, if any (other than petitioner) are known to the county judge to be residing within his jurisdiction, notifying them that application has been made for an inquiry into either the mental or the physical condition, or both, of the alleged incompetent and that a hearing on such application will be had before the judge having jurisdiction at the time and place to be specified in said notice. The hearings shall be conducted in as informal a manner as may be consistent with orderly procedure and in a physical setting not likely to have a harmful effect on the mental health of the proposed patient. The court shall receive all relevant and material evidence which may be offered and shall not be bound by the rules of evidence. An opportunity to be represented by counsel shall be afforded to every proposed patient, and if neither he nor others provide counsel, the court may appoint counsel.

(5) DETENTION OF ALLEGED INCOMPETENT.—

(a) If it appears, before the date of the hearing, from evidence produced before the judge, by affidavit or otherwise, that it is for the best interest of the alleged incompetent or others that he be detained for observation and examination, said judge may order that said alleged incompetent be placed in the protective custody of the spouse or of one or more of the near relatives of the incompetent or in the protective custody of any other responsible citizen of the state.

(b) The judge may, if in his opinion the public safety or the safety of the alleged incompetent requires it, direct that the sheriff forthwith confine said alleged incompetent in some specified place until the further proceedings herein provided for have been had, or until his further order; the judge may also order the detention of said person for such

reasonable time as may be necessary for proper medical observation and examination, not to exceed fifteen days, unless extended for good cause; provided, that in all such cases, there shall first be filed with said judge an affidavit setting forth facts which make such detention necessary.

(6) EXAMINING COMMITTEE.—

(a) The judge shall appoint an examining committee consisting of a responsible citizen of this state and two practicing physicians of good professional standing, each of whom shall be a graduate of a school of medicine recognized by the American medical association, which examining committee within a reasonable time after notice of their appointment, shall proceed to make such examination of said person as will enable it to ascertain thoroughly his mental and physical condition as of the time of the examination. No petitioner shall serve as a member of the examining committee.

(b) If the examining committee considers the person under examination to be incompetent, it shall determine whether the condition is acute or chronic, what the apparent cause is, and what hallucinations, if any, he has, and what the age and propensities of the person examined are. The report shall cover specifically the findings of the committee; it shall be on the form hereinafter prescribed, shall be signed by each member of the examining committee, and shall be transmitted immediately to the judge. If the report of the designated examiners is to the effect that the proposed patient is not mentally ill, the court may without taking any further action terminate the proceedings and dismiss the application.

(7) INDIGENCY OF INCOMPETENT; ATTORNEY'S FEES; WITNESSES.—

(a) The judge shall ascertain, or direct the examining committee to ascertain whether the person being examined is indigent or possesses sufficient available means for his support. This investigation may extend to the possibilities of acquiring property in the future.

(b) At any state of the proceeding the judge may, upon the application of any alleged incompetent who is indigent, appoint an attorney to represent said person, and the compensation of said attorney shall be fixed by the court in an amount not to exceed fifty dollars and shall be paid by the county commissioners out of the general fund of the county.

(c) If the alleged incompetent person is found to be indigent and unable to procure the attendance of witnesses in his behalf, the judge shall, upon written application therefor, summon a reasonable number of witnesses for such

person, and the witness and mileage fees of said witnesses shall be paid by the county commissioners of the county from its general fund.

(8) NOTICE; PROCESS; TESTIMONY.—In any trial or proceeding under this section, notice of hearing, service of notice or process, the taking of depositions, summoning of witnesses, and the taking of testimony shall be governed by rules pertaining to such matters in the general guardianship law of this state except as otherwise specified in this section.

(9) JUDGMENT.—If the judge, from the report of the examining committee and the hearing, finds that the person under investigation is incompetent, mentally or physically or both, he shall so adjudge, and his judgment shall set forth the nature and extent of the incompetency; but, if he finds that such person is not incompetent he shall dismiss the cause and discharge said person.

(10) EFFECT OF JUDGMENT.—

(a) After the judgment adjudicating a person to be mentally incompetent is filed in the office of the county judge, such person shall be presumed to be incapable, for the duration of such incompetency, of managing his own affairs or of making any gift, contract, or any instrument in writing which is binding on him or his estate. The filing of said judgment shall be notice of such incapacity.

(b) After a judgment adjudicating a person to be physically incompetent is filed in the office of the county judge, such person shall be presumed to be incapable, for the duration of such incompetency, of making any gift inter vivos or any contract which will bind him or his estate. The filing of said judgment shall be notice of such incapacity.

(11) COMMITMENT.—

(a) Whenever any person who has been adjudged mentally incompetent requires confinement or restraint to prevent self-injury or violence to others, the said judge shall direct that such person be forthwith delivered to the superintendent of the Florida state hospital, for care, maintenance, and treatment, as provided in §§394.09, 394.24, 394.25, 394.26 and 394.27, or make such other disposition of him as he may be permitted by law.

(b) The order of commitment shall be accompanied by a copy of the report of the exam-

ining committee, the judgment of mental incompetency, and copies of such other instruments and records as may be required by the board of commissioners of state institutions; said copies shall be delivered to the superintendent of the said hospital or his agent and shall be his authority for the detention and custody of said person.

(c) Where, however, the judge finds, from the report of the examining committee or otherwise, that such person does not require confinement or restraint to prevent self-injury or violence to others and that treatment in the Florida state hospital is unnecessary or would be without benefit to such person, he may further adjudge and decree that such person is harmless and that confinement or restraint of such person is unnecessary, and that he be delivered to a guardian of his person or to any responsible person who may offer to assume the care and custody of such harmless person, without cost to the state or county, or, if he is also found indigent and without funds for self-support, that he be delivered to the county commissioners of the county of his residence, for care and maintenance in the manner provided for paupers.

(d) After adjudication and commitment and before admission to the Florida state hospital the county judge for good cause shown may revoke said commitment and discharge the alleged incompetent.

(12) TEMPORARY HOSPITALIZATION AND CONFINEMENT OF PERSONS SUBJECT TO PROCEEDINGS OF ADJUDICATION OF MENTAL COMPETENCY.—

(a) Any person under a petition for examination to determine his mental competency before the county judge of any county in this state, as provided in this section, upon the recommendation of the examining committee appointed by the county judge, as provided in this section, that such person is, in the opinion of said examining committee only temporarily incompetent and through specialized treatment may be speedily restored to competency, may, by order of the county judge, be committed to an approved hospital with the consent of the hospital, and there be subject to observation and temporary treatment for a period to be fixed by the county judge, but in no event to exceed three months; such procedure shall be taken only upon application of a person authorized to file the petition as provided in subsection (2) of this section.

(b) Such order of commitment by the county judge shall not deprive the person so confined of any civil rights subject to final determination of his mental capacity. At the expiration of the period fixed by the order of the county judge, or upon the recommendation of the physician attending such person, at any time prior to the expiration of said period of confinement, the county judge shall reappoint the original examining committee, or appoint a new committee, who shall proceed into the examination of the mental capacity of such person, as provided by this section in original proceedings.

(13) PAYMENT FOR THE CARE OF COMMITTED INCOMPETENTS.—Reasonable charges and expenses for the care, maintenance and treatment of committed incompetents under any provision of this section and reimbursement for such charges and expenses that may be advanced by the state or any political subdivision thereof, shall be a lawful charge against the person and estate or property, real, tangible or intangible, of said incompetent in this state. Such charges and expenses may lawfully be paid from the estate of the said incompetent by any authorized personal representative, parent, or legal guardian of said incompetent; provided, however, that the payment thereof, in advance or otherwise, shall never be a prerequisite to the care, maintenance and treatment of any committed incompetent under any circumstances whatsoever. In cases of commitments to state hospitals or institutions, such charges and expenses shall be fixed or approved by the board of commissioners of state institutions of Florida. In the case of commitments to private hospitals or to public hospitals or institutions other than state hospitals or institutions, such charges and expenses shall be fixed or approved by the board of county commissioners of the county wherein the patient is or has been committed. Any suit or action instituted by the state or any political subdivision thereof for the recovery of such charges and expenses against the person or his duly authorized personal representative, parent, or legal guardian, shall be brought by the state attorney of the judicial circuit in which said incompetent was committed, or by the office of the attorney general or both such state attorney and office of the attorney general, as the case may be, as party plaintiff.

(14) HOSPITALIZATION BY AN AGENCY OF THE UNITED STATES.—If an individual ordered to be hospitalized pursuant to the previous section is eligible for hospital care or treatment by any agency of the United States, the court, upon receipt of such advice from such agency showing that facilities are available and that the individual is eligible for care or treatment therein, may order him to be placed in the custody of such agency for hospitalization. When any such individual is admitted pursuant to the order of such court to any hospital or institution operated by any agency of the United States within or without the state, he shall be subject to the rules and regulations of such agency. The chief officer of any hospital or institution operated by such agency and in which the individual is so hospitalized, shall with respect to such individual be vested with the same powers as the heads of hospitals within this state with respect to detention, custody, transfer, conditional release, or discharge of patients.

An order of a court of competent jurisdiction of another state, or of the district of Columbia, authorizing hospitalization of an individual by any agency of the United States shall have the same force and effect as to the individual while in this state as in the jurisdiction in which is situated the court entering the order; and the courts of the state or district issuing the order shall be deemed to have retained jurisdiction of the individual so hospitalized for the purpose of inquiring into his mental condition and of determining the necessity for continuance of his hospitalization, as is provided in this section with respect to individuals ordered hospitalized by the courts of this state. Consent is hereby given to the application of the law of the state or district in which is located the court issuing the order for hospitalization with respect to the authority of the chief officer of any hospital or institution operated in this state by any agency of the United States to retain custody, transfer, conditionally release, or discharge the individual hospitalized.

(15) RESTORATION TO MENTAL COMPETENCY; PROCEDURE.—

(a) In all cases where any person who has been heretofore, or hereafter may be adjudged incompetent, whether such person be confined in the Florida state hospital or has been discharged therefrom, or is in the custody of any person, persons, or committee, it shall be lawful for any relative, husband or wife, or next friend of such person as the case may be, to apply by petition to the county judge of the county where the alleged incompetent was adjudged incompetent, or where such person may be living at the date of such application, to have the mental status of such adjudged incompetent inquired into, as to whether such person is still incompetent and unable to manage his or her affairs; provided, however, that when the alleged incompetent is confined in the Florida state hospital, or any branch thereof, the proceedings shall be brought in the county in which said institution is located.

(b) Such petition shall contain all the facts upon which an order restoring such person to a judicially sound mental condition or status of competency is prayed, and shall be under oath. Such proceeding shall be ex parte and without respondent being named therein; provided however, that service of a copy of said petition shall be served upon the state attorney of the judicial circuit embracing the county in which the cause is brought, and he shall represent the state in such cases. In the event a legal guardian, as provided under the laws of Florida, has been appointed, of the person or property of said adjudicated incompetent, that then and in that event service of a copy of said petition for restoration shall be made upon said legally appointed guardian of the person or property of the adjudicated incompetent. Proof of service of copies of the notice, certificates, and petition shall be by affidavit or acknowledgment to be filed with the court.

(c) Upon the filing of such petition, the county judge of such county shall cause the adjudicated incompetent to be brought before him at an early date, after reasonable notice to the state attorney and legal guardian of said adjudicated incompetent; the time of said notice to be fixed by the county judge, at which time the issue in the said petition shall be tried, unless for the cause of justice the time shall be enlarged in the discretion of the court. In all other respects the hearing before the county judge on said petition shall be had in the same manner as the hearing provided in subsection (4) of this section.

(d) If upon the hearing of such cause it shall appear to the court that the adjudicated incompetent is of sound mind and is capable of managing his or her own affairs, the county judge hearing such cause shall immediately issue his order herein, which order shall be to the following effect:

1. That said person is of sound mind judicially and is capable of managing his own affairs.

2. That said person be immediately restored to his personal liberty.

3. That the guardian, committee, or custodian, as the case may be, of such person, shall, within thirty days, or such time as the county judge may fix, make full settlement with such person so restored to the status of judicial competency of all his or her property in their or his hands, custody or control, as the case may be, under penalty of contempt of court and the punishment thereof.

(e) The county judge entering such order shall forthwith cause a certified copy thereof to be forwarded to the office of the county judge of the county where said incompetent was originally committed, and said certified copy of order of restoration shall be filed in the original proceedings of record in said county; and a certified copy thereof shall be forwarded to the office of the superintendent of the Florida state hospital.

(16) RESTORATION TO MENTAL COMPETENCY; BY CERTIFICATE.—

(a) *Certificate.* When a person because of mental incompetency has been committed to the Florida state hospital, or to any institution known as a United States veterans bureau hospital, mentioned in §293.16, and when said person has been under observation at the said hospital or institution for a period of thirty days or more, if a majority of the medical staff of said hospital or institution who are graduates of schools recognized by the American medical association, are of the opinion that said person has recovered his reason and is capable of managing his own affairs, then the superintendent or the manager of said hospital or institution may issue to him a certificate so stating, signed by the three members of the medical staff of the said hospital or institution. Said certificate shall be attested by the superintendent or manager of the said hospital

or institution or someone designated by such superintendent or manager, and said certificate shall be admissible in evidence in any hearing for the restoration to sanity of such person and shall be prima facie proof that such person is sane.

(b) *Petition.* After the medical certificate has been issued as provided in the foregoing paragraph, showing that the person previously adjudged mentally incompetent has recovered his reason and is capable of managing his own affairs, the person named in said certificate, or his next friend or any of his next of kin, may file a petition in the county judge's court having jurisdiction of his case, setting forth the recovery of such incompetent and the reasons why he should be restored to his former status. Before said petition can be filed, or at the time it is filed, said certificate must be filed in the office of the county judge of the county where the judgment of mental incompetency and order of commitment were entered. If said certificate is not so filed in ninety days after its date, it shall be void. When said certificate has been filed, the petition may be filed at any time thereafter. The proceedings shall be the same in substance as those provided in subsection (15) of this section relating to restoration of mentally incompetent where no certificate has been filed or obtained.

(c) *Attorneys.* In cases of indigency the court, upon application of the incompetent, may appoint an attorney to represent faithfully such incompetent before the court. The attorney shall be entitled to a reasonable fee not to exceed fifty dollars, to be allowed by the county judge and paid by the county commissioners of the county from the county's general fund.

(17) REMOVAL OF PHYSICAL INCOMPETENCY.—

(a) *Petition.* After a judgment of physical incompetency has been entered, if the person affected thereby shall at any time thereafter become able to care for his property, he or one or more of his family or any of his next of kin may petition the court having jurisdiction of his case, setting forth the recovery of such incompetent and the reasons why he should be restored to his former status.

(b) *Notice and hearing.* The judge shall set a time for the hearing of such petition, and reasonable notice of the hearing shall be given to the incompetent, if he is not the petitioner, and to one or more of the members of his family, if any, and, if he has no family, or next of kin, known to the county judge to be within his jurisdiction, then such notice shall be given as the judge may direct.

(c) *Order.* After the hearing, if the judge shall find that such person has regained the ability to care for his property, an order to that effect shall be entered, and thereupon, such person, so far as his person and property are concerned, shall occupy the same status as though he had never been adjudicated incompetent. If a guardian has been appointed for him during such physical incompetency, such guardian shall immediately render his accounting to the court having jurisdiction and apply for his discharge as provided by the general guardianship laws of this state.

(18) FORMS.—The board of commissioners of state institutions shall cause to be prepared and prescribe forms for applications, notices, medical reports, orders of commitment, and such other forms as may be found necessary or convenient, in administering this law. The board of commissioners of state institutions shall cause said forms to be printed and distributed to the county judges of this state.

(19) APPLICATION OF THIS SECTION.—The provisions of this section shall be cumulative to all other laws on the restoration of sanity.

History.—§2, ch. 4787, 1895; §1, ch. 5264, 1903; GS 1201; RGS 2569; CGL 3925, repealed by §6, ch. 22000, 1943. §3, ch. 23157, 1945; §3, ch. 29909, 1955.

Kenneth DONALDSON, Plaintiff-Appellee,

v.

J. B. O'CONNOR, M. D. and John Gumanis, M. D.,
Defendants-Appellants.

No. 73 1813.

RECEIVED
JUN 26 1974
ATTORNEY GENERAL'S
OFFICE

United States Court of Appeals,
Fifth Circuit.

April 26, 1974.

Former patient who had been involuntarily committed, under civil commitment procedures, to state mental hospital brought action against attending physicians and others for deprivation of alleged constitutional right to receive treatment or be released from the hospital. The United States District Court for the Northern District of Florida, David L. Middlebrooks, Jr., J., rendered judgment against the attending physicians and they appealed. The Court of Appeals, Wisdom, Circuit Judge, held that patient had constitutional right to such treatment as would help him to be cured or to improve his mental condition; that evidence supported finding that attending physicians had acted in bad faith with respect to their treatment of patient and were personally liable for his injuries or deprivations of his constitutional rights; and that limitation period did not begin to run until patient's release from the hospital.

Affirmed.

1. Appeal and Error ⇐233(2)

Defendants' objections to instructions given at plaintiff's request were properly before the court on review of judgment in favor of plaintiff even though defendants did not object to

Synopsis, Syllabi and Key Number Classification
COPYRIGHT © 1974, by WEST PUBLISHING CO.
The Synopsis, Syllabi and Key Number Classification constitute no part of the opinion of the court
INDEXED

the instructions when they were discussed in chambers or after charge was read to jury where defendants did object to the instructions in a pretrial brief.

2. Constitutional Law ⇐255(5)

Where nondangerous patient is involuntarily committed under civil commitment procedures to state mental hospital, only constitutionally permissible purpose of confinement is to provide treatment and patient has due process right to such treatment as will help him to be cured or to improve his mental condition. U.S.C.A.Const. Amend. 14; 42 U.S.C.A. § 1983.

3. Constitutional Law ⇐255(1)

Generally, as matter of due process, long-term detention is permitted only when an individual is proved, in a proceeding subject to limitations of due process clause, to have committed a specific act defined as an offense against the state and such detention is allowed only for period of time explicitly fixed by sentence. U.S.C.A.Const. Amend. 14.

4. Constitutional Law ⇐255(1)

Where detention of individual is not in retribution for a specific offense, is not limited to fixed term and has not been preceded by proceeding in which fundamental procedural safeguards have been observed, there must be a quid pro quo, such as rehabilitative treatment or minimally adequate habilitation and care where rehabilitation is impossible, in order to justify confinement. U.S.C.A.Const. Amend. 14.

5. Civil Rights ⇐13.13(3)

In action by former mental patient who had been involuntarily committed under civil procedures to state mental hospital against attending physicians for deprivation of right to receive treatment or be released, evidence concerning withholding of treatment, blocking of efforts to have patient released, confinement of patient even though he was not dangerous or with reckless disregard as to whether he was dangerous and failure to do best that could have been done with available resources sustained determination that attending physicians had acted in bad faith and were personally liable for injuries sustained by patient and for deprivation of patient's right to receive treatment. U.S.C.A.Const. Amend. 14; 42 U.S.C.A. § 1983.

6. Federal Civil Procedure ⇐2096

Objection to composition of jury was not timely raised where it was not mentioned until after jury was impanelled. 28 U.S.C.A. § 1863(b)(5).

7. Federal Civil Procedure ⇐2092

Jury selection plan allowing certain specified classes of persons, including actively engaged members of the clergy and actively practicing attorneys, physicians, dentists and nurses to be excused from jury duty if they desired was in compliance with Jury Selection and Service Act. 28 U.S.C.A. § 1863(b)(5); U.S.C.A.Const. Amend. 7.

8. Limitation of Actions ⇐58(1)

Limitation period applicable to civil rights action brought by former patient of state mental hospital against attending physician for deprivation of his right to receive treatment or be released did not begin to run until patient's release from hospital; period did not begin to run on date patient was taken from care of defendant physician. 42 U.S.C.A. § 1983; F.S.A. § 95.11(4), (5)(a), (6).

9. Limitation of Actions ⇐55(6)

When tort involves continuing injury, cause of action accrues and limitation period begins to run at time tortious conduct ceases.

10. Limitation of Actions ⇐55(6)

Cause of action for false imprisonment does not accrue until release of imprisoned party.

11. Courts ⇐375(4)

In a civil rights suit, even though state statute of limitation is applicable, question of when cause of action has accrued is a matter of federal rather than state law. 42 U.S.C.A. § 1983.

12. Civil Rights ⇐13.4(1)

Attending physician was not entitled to immunity from liability under Civil Rights Act for deprivation of right of patient at state mental hospital to receive treatment absent finding that he had acted in good faith. 42 U.S.C.A. § 1983.

13. Civil Rights ⇐13.8(1)

Full range of officials' immunities available at common law does not apply in actions brought under Civil Rights Act. 42 U.S.C.A. § 1983.

14. Civil Rights ⇐13.13(3)

Evidence that physicians who attended patient who had been involuntarily committed to state mental hospital had acted maliciously, wantonly or oppressively was sufficient to sustain award of punitive damages for deprivation of patient's right to receive treatment or be released. 42 U.S.C.A. § 1983.

15. Civil Rights ⇐13.10

Failure of patient who had been involuntarily committed to state mental hospital to petition for restoration of his competency did not preclude determination that attending physicians had deprived patient of his right to receive treatment or to be released where state law did not permit person adjudged incompetent to petition on his own for restoration of competency. F.S.A. § 394.22.

Appeals from the United States District Court for the Northern District of Florida.

Before RIVES, WISDOM and MORGAN, Circuit Judges.

WISDOM, Circuit Judge:

This case requires us to decide for the first time the far-reaching question whether the Fourteenth Amendment guarantees a right to treatment to persons involuntarily civilly committed to state mental hospitals. The plaintiff-appellee, Kenneth Donaldson, was civilly committed to the Florida State Hospital at Chattahootchee in January 1957, diagnosed as a "paranoid schizophrenic". He remained in that hospital

for the next fourteen and a half years. During that time he received little or no psychiatric care or treatment.

Donaldson contends that he had a constitutional right to receive treatment or to be released from the state hospital. In this action, filed February 24, 1971, he seeks damages under 42 U.S.C. § 1983 [1] against five hospital and state mental health officials who allegedly deprived him of this constitutional right.[2] A jury returned a verdict of $28,500 in compensatory damages, and $10,000 in punitive damages against the two defendants-appellants, Dr. J. B. O'Connor and Dr. John Gumanis. Dr. O'Connor, as Acting Clinical Director of the Hospital, was Donaldson's attending physician from the time of his admission until mid-1959. He was Clinical Director of the Hospital from mid-1959 until late 1963, and Superintendent thereafter until his retirement February 1, 1971. Dr. John Gumanis was Donaldson's attending physician from the fall of 1959 until the spring of 1967. He was added as a defendant by an amended complaint filed April 20, 1972. The jury returned a verdict in favor of the other three defendants.

Gumanis and O'Connor bring separate appeals to this Court. They challenge the sufficiency of the evidence to support the

1. 42 U.S.C. § 1983 provides:
   Every person who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

2. Except when the text clearly indicates otherwise, we use the term "defendants" in this opinion to refer to Dr. Gumanis and Dr. O'Connor, against whom judgments were rendered. The other three who were sued were: Dr. Francis G. Walls, who became Acting Superintendent of the Hospital when O'Connor retired from that position in February 1971, and who held that position for about four months; Dr. Milton J. Hirschberg, who became permanent Superintendent, succeeding O'Connor, in June 1971; and Emmett S. Roberts, Secretary of the Department of Health and Rehabilitative Services in Florida at the time Donaldson filed his First Amended Complaint August 30, 1971.

jury verdict [3] and they contend that the Constitution does not guarantee a right to treatment to mental patients involuntarily civilly committed. Both argue, therefore, that the trial judge erred in denying a motion to dismiss for failure to state a claim and in instructing the jury that civilly committed mental patients have a constitutional right to treatment. In addition, Gumanis raises a number of lesser issues. We hold that the Fourteenth Amendment guarantees involuntarily civilly committed mental patients a right to treatment, and that the evidence was sufficient to support the verdict. We also reject the numerous lesser contentions advanced by Gumanis. Accordingly, we affirm the judgment in Donaldson's favor.

I.

To put the legal issues in proper context as well as to discuss the defendants' challenge to the sufficiency of the evidence, it is essential to review the facts in unusual detail.

Donaldson was committed January 3, 1957, on the petition of his father and after a brief hearing before a county judge of Pinellas County, Florida. He was admitted to the Florida State Hospital twelve days later, and soon thereafter was diagnosed as a "paranoid schizophrenic". The committing judge told Donaldson that he was being sent to the hospital for "a few weeks" to "take some of this new medication", after which the judge said that he was certain that Donaldson would be "all right" and would "come back here". Donaldson was not released until July 31, 1971, after he had instituted this suit.

3. The defendants raised the question of the sufficiency of the evidence on a motion for directed verdict made at the close of the plaintiff's evidence, and renewed at the close of all evidence. The defendants apparently did not move for judgment notwithstanding the verdict after the verdict was returned, but they did move for a new trial. The first ground they asserted in their motion for new trial was that "[t]he verdict is contrary to the clear weight of the evidence, which evidence showed that Defendants reasonably believed in good faith that due to his mental illness and need of treatment Plaintiff was properly confined".

There is little dispute about the general nature of the conditions under which Donaldson was confined for almost fifteen years. Donaldson received no commonly accepted psychiatric treatment. Shortly after his first mental examination, Donaldson, a Christian Scientist, refused to take any medication or to submit to electroshock treatments, and he consistently refused to submit to either of these forms of therapy. No other therapy was offered. At trial, Gumanis mentioned "recreational" and "religious" therapy as forms of therapy given Donaldson; but this amounted to allowing Donaldson to attend church and to engage in recreational activities, privileges he probably would have been allowed in a prison. In the oral argument on appeal the appellants' counsel made much of what they called "milieu therapy", which they said was given Donaldson. This was nothing more than keeping Donaldson in a sheltered hospital "milieu" with other mental patients; the defendants did not refer to anything specific about the "milieu" that was in any special way therapeutic.[4] Donaldson was usually confined in a locked room, where, according to his testimony, there were about sixty beds, with little more room between beds than was necessary for a chair; his possessions were kept under the bed.

At night he was often wakened by some who had fits and by some "who would torment other patients, screaming and hollering". Then there was "the fear, always the fear you have in your heart, I suppose, when you go to sleep that maybe somebody would jump on you during the night". A

4. "Milieu therapy" is a frequent response by doctors and hospitals to claims by patients that they are receiving inadequate treatment. See Halpern, A Practicing Lawyer Views the Right to Treatment, 1969, 57 Geo.L.J. 782, 786-87, n. 19. Halpern discusses "milieu therapy" in discussing Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451, in which the District of Columbia Court of Appeals held that there was a statutory right to treatment. He notes that "milieu therapy" is an "amorphous and intangible" concept, "the easiest therapeutic claim for an institution to assert and the most difficult for a patient to refute", Halpern, *supra*, at 787 n. 19.

third of the patients in the ward were criminals. Indeed, Donaldson testified, "The entire operation of the ward was geared to criminal patients.[5]"

5. Some of Donaldson's testimony relating the conditions under which he lived is worth quoting:

"Q. Now, in the buildings you lived in Department A, were those buildings locked?
A. Yes, sir.
Q. Were the wards you lived on locked?
A. Yes.
Q. Were there metal enclosures on the windows?
A. Yes, padlocks on each window.
Q. Approximately how many beds were there in the rooms where you slept?
A. Sixty some beds.
Q. How close together were they?
A. Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.
Q. Did you have chairs in the room you were in?
A. There wasn't a chair in the room I was in.
Q. All right, was there an outside exercise yard for your department?
A. Yes, there was one period in particular when nobody went out for two years.
Q. Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?
A. That is right.
Q. Were there criminal patients on your ward?
A. There were criminal patients on the ward.
Q. Approximately what percent of the population on your ward were criminals?
A. Looking back, roughly, I would say a third. I do not know the figures for the whole department.
Q. Let's just talk about your ward.
A. Okay, I would say about a third in the wards I was in.
Q. Now, did you sleep in the same rooms as the criminal patients?
A. Yes.
Q. Did you get up at the same time?
A. Yes.
Q. Did you eat the same food?
A. Yes.
Q. In the same dining room?
A. Yes.
Q. Did you wear the same clothes?
A. Yes. The entire operation of the wards I was on was geared to the criminal patients.

BEST COPY AVAILABLE

During his first ten years at the hospital, progress reports on his condition were irregularly entered at intervals averaging about one every two and a half months. During those first ten years, he requested grounds privileges and occupational therapy; his requests were denied. In short, he received only the kind of subsistence level custodial care he would have received in a prison, and perhaps less psychiatric treatment than a criminally committed inmate would have received.

At the time Donaldson was admitted to the hospital in 1957, O'Connor was Assistant Clinical Director of the hospital. As Assistant Clinical Director, he was in charge of the hospital's Department A, then the white male ward, where Donaldson was assigned upon his admission to the hospital. In that

Q. Let me ask you, were you treated any differently from the criminal patients?
A. I was treated worse than the criminal patients.
Q. In what sense were you treated worse?
A. The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.
Q. For the criminal?
A. On the criminal patients, and that would be a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.
Q. Was there a place on the ward you had access to for keeping personal possessions?
A. No, not at that time.
Q. What did you do with your personal possessions?
A. I kept mine in a cedar box under the mattress of my bed.
Q. Was there a place in the wards where you could get some privacy?
A. No, not anytime in all of the years I was locked up.
Q. Were you able to get a good nights sleep?
A. No.
Q. Why not?
A. On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night.
They never did, but you think about those things. It was a lunatic asylum."

position, O'Connor was Donaldson's attending physician. At that time, Gumanis was a staff physician in Department A. On July 1, 1959, O'Connor became Clinical Director of the hospital, and in the fall of 1959, Gumanis was placed in charge of Department A, and became Donaldson's attending physician. O'Connor was promoted from the position of Clinical Director to the position of Superintendent July 30, 1963, and served as Superintendent until he retired February 1, 1971. Gumanis served as Donaldson's attending physician until April 18, 1967, when Donaldson was transferred to Department C, until that time the Negro male ward. After the transfer, Donaldson's attending physician was Dr. Israel Hanenson, the head of Department C until Dr. Hanenson's death in the fall of 1970. After that, until his release, Donaldson's attending physician was Dr. Jesus Rodriguez.

Donaldson brought this suit while he was still a patient at the hospital. In his original complaint, Donaldson sought to bring this suit as a class action on behalf of all patients in the hospital's Department C. In addition to damages, to the plaintiff and to the class, the complaint sought habeas corpus relief directing the release of Donaldson and of the entire class, and sought broad declaratory and injunctive relief requiring the hospital to provide adequate psychiatric treatment.

After Donaldson's release, and after the district court dismissed the action as a class suit, Donaldson, on August 30, 1971, filed his First Amended Complaint. This complaint sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. The complaint asked the district court to convene a three-judge district court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30 however, the plaintiff in a memorandum brief abandoned the prayer that a three-judge

court be convened. The prayers for injunctive and declaratory relief therefore were effectively eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights". The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionally limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization". Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on this verdict, Gumanis and O'Connor appeal.

The trial centered, of course, upon the conditions of Donaldson's confinement and upon the defendants' behavior toward Donaldson. On the record as a whole, there was ample

evidence to support the jury's reaching any or all of the conclusions set forth in the following subsections in Part I of this opinion.

A. *The defendants unjustifiably withheld from Donaldson specific forms of treatment.*

The evidence establishes that there were at least three forms of treatment the defendants withheld from Donaldson.

First, he was denied grounds privileges. Since the purpose of hospitalization is to restore the capacity for independent community living, one of the most basic modes of treatment is giving a patient an increasing degree of independence and personal responsibility. One of the plaintiff's expert witnesses was Dr. Walter Fox, Director of the Arizona Mental Health Department and former president of the Association of Medical Superintendents of Mental Hospitals. He had interviewed Donaldson and examined his hospital record. Fox testified that confining Donaldson to a locked building, with no opportunity for grounds privileges was not "consistent" with a treatment plan for a patient with Donaldson's history.

Gumanis denied Donaldson a privilege card, even after Donaldson had asked him for one. Fox testified that it would have been "standard psychiatric practice" to extend grounds privileges to a patient of Donaldson's background, condition, and history. Gumanis, in his testimony at trial, could not give a convincing explanation for his refusal of grounds privileges to Donaldson.[6] At one point he sought to shift the responsibility for the refusal to O'Connor's shoulders, saying that he recalled having denied privileges after consultation with O'Connor. Later, he testified that at the time in question Donaldson had appeared to him to be "really upset", and that

6. Donaldson testified that he had once escaped from the hospital. This occurred around Christmastime 1957, shortly before the end of the first year Donaldson had spent at Florida State. The hospital records, however, did not show that a fear Donaldson would attempt to escape again motivated the denial of grounds privileges; nor have Gumanis and O'Connor asserted before this Court that such a fear was their reason for denying Donaldson a card.

he had "probably" made the decision to deny Donaldson a privilege card on his own.

Donaldson testified that soon after his transfer to Department C, Dr. Hanenson, the physician in charge of that department, gave him a privilege card.

The second form of treatment denied Donaldson was occupational therapy. Donaldson testified that Gumanis consistently refused to allow him to enter occupational therapy. This testimony was borne out by a progress note entered in Donaldson's hospital record January 17, 1964. Again, Fox testified that given what he called Donaldson's "social history", Donaldson would have been ideally suited to benefit from occupational therapy. According to Donaldson, Gumanis did not want him to go into occupational therapy, because Gumanis feared that he would learn touch-typing and would use this skill, in Donaldson's words, to "write writs", that is, to prepare habeas corpus petitions. Gumanis gave no reason why he denied Donaldson occupational therapy, although in the course of his testimony he did allude to the fact that he had done so. Not until Donaldson was transferred to Dr. Hanenson's care was he allowed to enter occupational therapy.

Third, the simplest and most routine form of psychiatric treatment is to have a patient talk with a psychiatrist. Donaldson testified that in the eighteen months O'Connor was in direct charge of his case, he spoke with O'Connor "not more than six times", and that the total time he spent talking to O'Connor did not consume more than one hour. He testified that in the eight and one-half years he spent under Gumanis' care, he did not speak with Gumanis more than a total of two hours—an average of about fourteen minutes a year. He testified that neither Gumanis nor O'Connor ever heeded his requests to discuss his case. On one occasion Gumanis said that he "talked only to patients that he wanted to". Gumanis did not recall that conversation. Once again, there was evi-

dence to show that the situation improved when Donaldson was transferred to Dr. Hanenson's care. Donaldson testified that Hanenson managed to speak with him once a week, even though, according to Donaldson, patients were more numerous, psychiatrists fewer, and conditions worse in Hanenson's Department C than they had been in Gumanis' Department A.

B. *The defendants recklessly failed to attend to and treat Donaldson at precisely those junctures when treatment could have most helped Donaldson recover and therefore be released.*

The jury could have concluded that Donaldson should have been marked, at his entrance to the hospital, as a prime candidate for an early release, and that the defendants acted recklessly in failing to treat or attend to him during the early stage of his confinement. Fox testified that, given Donaldson's history,[7] he should have been "pegged" for an "early discharge". Moreover, a progress note entered by Gumanis after his first diagnostic interview with Donaldson, March 25, 1957, recorded that Donaldson "appeared" to be "in remission". Gumanis defined "remission" for the jury as a state "when the patient does not express delusions or paranoid ideas", and told the jury that it was hospital practice to release patients who were in remission. He testified that Donaldson was not released because he wanted to "observe [Donaldson] further". But after that interview the first progress note entered in Donaldson's hospital record is dated four months later; and the next report five months after that. Asked about this, Gumanis first replied, "When you have 900 patients you do that"; later, he insisted that he had seen Donaldson frequently, but had not recorded progress notes after each observation. The jury, however, could have discounted this testimony and concluded that Gumanis acted wantonly in giving a patient who had appeared to be "in remission" the same treatment he gave his 900 other patients.

7. Fourteen years before he was hospitalized in Florida, Donaldson had been hospitalized at the Marcy State Hospital in New York, with the same diagnosis as that made by the Florida doctors—"paranoid schizophrenic". On that occasion, Donaldson was released after three months.

C. *The defendants wantonly, maliciously, or oppressively blocked efforts by responsible and interested friends and organizations to have Donaldson released to their custody.*

At issue here are two efforts made to secure Donaldson's release, one by Helping Hands, Inc., a Minneapolis organization which runs halfway houses for mental patients and John H. Lembcke, a college friend of Donaldson.

1. *The Helping Hands' attempt to obtain Donaldson's release.*

Helping Hands made an inquiry to the hospital concerning the possibility of releasing Donaldson to its custody by a letter dated June 6, 1963:

> We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters.

Enclosed with the letter was a brochure describing Helping Hands and a letter from the Minneapolis Clinic of Psychiatry and Neurology, stating that "it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care" provided at Helping Hands. The author of this letter pointed out that the woman identified by the letterhead as the founder and director of Helping Hands had "rehabilitated well over a thousand over the years". The letter requested information concerning Donaldson's age, health, and "qualifications for work".

The hospital responded June 17, 1973, in a letter signed by O'Connor, then Clinical Director of the hospital. It gave

Donaldson's age, and answered inquiries concerning his health and qualifications for work with the bare statement that Donaldson was "mentally incompetent at the present time." The crisp concluding paragraph read:

> Should he [Donaldson] be released from this Hospital, he will require very strict supervision, which he would not tolerate. Such a release would be to the parents. We see no prospects of his release to any third party at any time in the near future.

The jury could have decided that Gumanis and O'Connor acted wantonly and maliciously in issuing this response, and that this conduct foreclosed an opportunity for Donaldson to win back at least a part of his freedom, and to gain access to a level of psychiatric treatment unavailable to him at the Florida Hospital. Each of the defendants sought to shift the responsibility for sending this curt reply to the other's shoulders. They discussed the question in terms of whether hospital rules, in general, fixed responsibility for deciding whether a patient could be furloughed by the attending physician, or the Superintendent or Clinical Director; they did not discuss it in terms of their recollections of the particular event. The jury would have been justified in finding the two jointly responsible for the incident.

2. *The Lembcke attempt to obtain Donaldson's release.*

John H. Lembcke, a certified public accountant, in Binghamton, New York, who is married and has three children, had been a classmate of Donaldson's at Syracuse University in the 1920's. On four occasions, Lembcke sought to have Donaldson released to his custody. The first was on July 3, 1964, when Lembcke informed the hospital that Donaldson was a friend of his, and inquired whether there were "any conditions under which he would be released so that I could bring him back to New York State". The same day the hospital received the letter, O'Connor pencilled a note to Gumanis that is

attached to the letter in Donaldson's hospital record. The note said:

> This man must not be well himself to want to get involved with someone like this patient, who even the recent visiting psychologist considered *dangerous*—Recommend turn it down.

Rich, the new Clinical Director, wrote Lembcke saying that Donaldson had "shown no particular changes mentally", and that if released he would "require complete supervision".

The second inquiry came by letter of November 27, 1964. Again O'Connor appended a note to Gumanis that is in the hospital records. This note gave three reasons for denying Lembcke's request to have Donaldson released to him: parental consent would be required; the patient "would not stay with party mentioned"; and "we don't know anything about party". Gumanis prepared a letter, dated November 27 and again signed by Dr. Rich, "advis[ing]" Lembcke that Donaldson would "require further hospitalization". The reply did not mention the three reasons for the denial set out in O'Connor's note, and did not request any further information from Lembcke, even though Lembcke in his November 23 letter had offered to provide any information the hospital should request.

The third attempt by Lembcke began with another letter to the hospital, dated December 21, 1965. According to Lembcke's testimony, the hospital responded by saying Donaldson could be released on two conditions: (1) that Lembcke would give Donaldson "adequate supervision" so that the release would not be detrimental to his mental health; and (2) that Lembcke would secure parental permission for Donaldson to go to New York with Lembcke. In May 1966, Lembcke went to Florida, and met with Gumanis and O'Connor. While in Florida he saw Donaldson and obtained from Donaldson's parents a letter dated May 14, 1966, giving their consent to Donaldson's being released to him. Nothing happened. In his

testimony Lembcke did not explain how or why he came to abandon this 1966 effort to secure his friend's release.

Lembcke's final and most important effort to secure Donaldson's release began in March 1968. On March 21, the General Staff, at a meeting attended by Gumanis and Hanenson but not by O'Connor, recommended Donaldson's release on a trial visit or out-of-state discharge. On March 24, Lembcke wrote the hospital renewing his offer to take Donaldson. On March 28, the hospital responded, imposing three conditions on Donaldson's release: (1) that Lembcke be willing to come for Donaldson; (2) that he be willing to supervise Donaldson; and (3) that he be willing to take Donaldson to a psychiatrist if Donaldson needed treatment. By letter of March 31, Lembcke acceded to these conditions. On April 4, the hospital replied with a letter imposing two additional conditions: (1) a detailed statement concerning the home supervision Donaldson would be given; and (2) written authorization for the release from Donaldson's parents. Lembcke wrote back giving the hospital the information about home supervision it requested. The hospital replied by again saying it would be necessary to obtain the written consent of Donaldson's parents.

On September 18, 1968, Lembcke wrote the hospital, enclosing a photocopy of the notarized written permission Donaldson's parents had signed May 14, 1966. The hospital responded in a letter dated September 24, signed by Dr. Rich. The letter informed Lembcke that Donaldson had been mentally ill for many years, that he "still express[ed] delusional thinking" and that "it would not be fair to you or to him to release him from the hospital at this time without adequate planning". The letter added, in its final paragraph, that it would be necessary for the hospital to have more recent authorization from Donaldson's nearest relative than the one Lembcke had proffered. At that point, Lembcke gave up; whenever he met the conditions imposed by the hospital officials, new

conditions were imposed. As he put it, "after requirements were met, requirements were increased".

One other facet of Lembcke's last attempt to secure Donaldson's release bears mention. As noted, O'Connor did not attend the Staff Conference which had recommended Donaldson's release March 21. O'Connor first learned of the hospital's recommendation in June, when Donaldson wrote to the Division Director of the hospital concerning the effort being made to release him. The division director forwarded the letter to O'Connor, who in turn forwarded it to Hanenson, asking for information concerning the proposed release. Hanenson responded with a memorandum dated June 17. Across the bottom of this memorandum, O'Connor pencilled in the remark, "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise the patient". It was not clear when O'Connor supposed this "decision" to have been made, and in his deposition O'Connor was unable to locate any record of it in the hospital record. Moreover, there were suggestions in the record that Dr. O'Connor's conduct, in this and other respects, was influenced by his knowledge of Donaldson's history of writing letters to the press and to outside officials. From all of this evidence, the jury would have been justified in concluding that the frustration of Lembcke's effort to secure Donaldson's release in 1968 was entirely or primarily the result of O'Connor's bad faith intervention or, at the least, that the intervention was in reckless disregard of Donaldson's rights.

D. *The defendants continued to confine Donaldson knowing he was not dangerous, or with reckless disregard for whether he was dangerous.*

Three of the plaintiff's expert witnesses—Fox, Raymond D. Flowler, Jr., Chairman of the Psychology Department at the University of Alabama and former President of both the Alabama and Southern Psychological Associations, and Julian Davis, Director of the Psychology Department at the Florida State Hospital—testified that they did not believe Donaldson

was dangerous. Fox's and Flowler's opinions were based upon readings of the hospital records, Donaldson's psychological reports, Donaldson's past history, and raw data from his psychological examination. Lembcke testified that in his half century of having known Donaldson, he had never known Donaldson to be "violent", "aggressive", or "belligerent"; that, on the contrary, he knew Donaldson to be a "gentle" man. Dr. Walls testified that he did not believe Donaldson was physically dangerous; Gumanis himself conceded that he did not think Donaldson dangerous while Donaldson was in the hospital, although he said he could not predict what Donaldson would be like outside the hospital. There was no evidence in the record of Donaldson's ever having been violent in any way.

On the basis of this testimony the jury would have been justified in finding that Donaldson was not dangerous, and in inferring that the defendants knew him to be so.

E. *The defendants did not do the best they could with available resources.*

As they did in the district court, the defendants on appeal pitch their defense in substantial part on their contention that they did the best they could with limited resources available to the state psychiatric hospital. Donaldson rebuts this contention, first, by pointing out the contrast between the treatment he received from the defendants and that he received from Hanenson. Hanenson allowed him grounds privileges and occupational therapy, spoke with him frequently, and within a year of taking charge of his case arranged a staff conference that recommended his release. Second, he relies on the testimony of Fox and the other experts to the effect that Gumanis and O'Connor failed to take steps that would have been open to them to take, even given the admittedly stark limitations on the resources available to them. We agree that these two considerations were a sufficient basis for the jury to reject the defendants' defense that they did the best they could with available resources.

We turn now to the novel and important question whether civilly committed mental patients have a constitutional right to treatment.

II.

[1] The theory of Donaldson's cause of action under section 1983 was set forth in three of the instructions given by the trial judge. The first, instruction number 34, was a variation of a standard form "boiler plate" instruction found in 2 Dewitt & Blackmer's Federal Jury Practice & Instructions, 1970, § 87.05 (2d ed.) This instruction stated that there were four basic elements Donaldson had to prove to make out a claim under § 1983: (1) that the defendants "confined plaintiff against his will, knowing that he was not mentally ill or dangerous, and knowing that if mentally ill he was not receiving treatment for his mental illness"; (2) that defendants "then and there acted under the color of state law"; (3) that defendants' "acts and conduct deprived the plaintiff of his federal constitutional right not to be denied his liberty without due process of law as that phrase is defined and explained in these instructions"; and (4) that the defendants' "acts and conduct were the proximate cause of injury and consequent damage to the plaintiff". The other two instructions, 37 and 38, were the relevant instructions "defin[ing] and explain[ing]" the "phrase", "federal constitutional right not to be denied or deprived of his liberty without due process of law", within the meaning of instruction 34. These instructions told the jury:

37. You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such individual treatment as will give him a realistic opportunity to be cured or to improve his mental condition.

38. The purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not dangerous to himself or others. Without such

> treatment there is no justification, from a constitutional standpoint, for continued confinement.

The propriety of these two instructions is the heart of the question raised by both O'Connor and Gumanis in their appeals.[8]

[2] The question for decision, whether patients involuntarily civilly committed in state mental hospitals have a constitutional right to treatment, has never been addressed by any of the federal courts of appeals. Three district courts, however, have decided the question within the last three years, two of which held that there is a constitutional right to treatment.[9]

8. As a threshold matter, Donaldson suggests that the objections to these instructions are not properly before this Court. He notes that the defendants did not object to that instruction either when the proposed instructions were discussed in chambers, or after the charge was read to the jury. The defendants did, however, object to what were then the plaintiff's proposed instructions 37 and 38 in a pretrial brief filed before the Court. There they asked that those instructions be replaced with an instruction that "[y]ou are instructed that a person who is committed to a mental hospital has a right to be released through judicial process when through no fault of his own treatment is not afforded and he is not dangerous to society or to himself". The trial judge refused this request, and gave the two instructions as the plaintiffs had proposed them. It is settled that "a failure to object may be disregarded if a party's position has previously been made clear to the court and it is plain that a further objection would be unavailing". 9 C. Wright & A. Miller, Federal Practice & Procedure § 2553 at 639-40; see, *e. g.*, Mays v. Dealers Transit, 7 Cir. 1971, 441 F.2d 1344; Steinhauser v. Hertz Corp., 2 Cir. 1970, 421 F.2d 1169. We find that was the case here, and therefore we consider that the objections are properly before the Court.

9. Two cases hold that there is a right to treatment for civilly committed mentally ill patients. Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, *on submission of proposed standards by defendants*, 334 F.Supp. 1341, enforced, 1972, 344 F.Supp. 373, 387, appeal docketed sub nom., Wyatt v. Aderholt, No. 72-2634, 5 Cir. Aug. 1, 1972; Stachulak v. Coughlin, N.D.Ill., 1973, 364 F.Supp. 686. One has held civilly committed mentally ill patients enjoy no right to treatment. Burnham v. Department of Public Health, N.D.Ga.1972, 349 F.Supp. 1335, appeal docketed, No. 72-3110, 5 Cir., Oct. 4, 1972.
A fourth case has recently held that civilly committed mentally retarded patients have a right to treatment. Welsch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, — F.Supp. —.

The Court of Appeals for the District of Columbia Circuit, in a case decided eight years ago, took note in dictum of the existence and seriousness of the question, although in the same case the court held that the Hospitalization of the Mentally Ill Act of 1964[10] creates a *statutory* right to treatment on the part of mental patients in the District of Columbia.[11] The idea of a constitutional right to treatment has received an unusual amount of scholarly discussion and support,[12] and there is now an enormous range of precedent

10. D.C.Code Ann. § 21-501.

11. Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451. Chief Judge Bazelon wrote for the Court:

> Absence of treatment "might draw into question 'the constitutionality of [this] mandatory commitment section' as applied." (1) Lack of improvement raises a question of procedural due process where the commitment is under D.C.Code § 24-301 rather than under the civil commitment statute, for under § 24-301 commitment is summary, in contrast with civil commitment safeguards. It does not rest on any finding of present insanity and dangerousness but, on the contrary, on a jury's reasonable doubt that the defendant was sane when he committed the act charged. Commitment on this basis is permissible because of its humane therapeutic goals. (2) Had appellant been found criminally responsible, he could have been confined a year, at most, however dangerous he might have been. He has been confined four years and the end is not in sight. Since this difference rests only on need for treatment, a failure to supply treatment may raise a question of due process of law. It has also been suggested that a failure to supply treatment may violate the equal protection clause. (3) Indefinite commitment without treatment of one who has been found not criminally responsible may be so inhumane as to be "cruel and unusual punishment." [Footnotes and citations omitted]

Id. at 453.

12. The landmark article in the field is Birnbaum, The Right to Treatment, 1960, 46 A.B.A. Journal 499. Much of the commentary in the area was stimulated by the *Rouse* decision. *E. g.*, Symposium—The Right to Treatment, 1969, 57 Geo.L.J. 673 (11 articles, 218 pages); Bazelon, Implementing the Right to Treatment, 1969, 36 U.Chi.L.Rev. 742; Birnbaum, Some Remarks on "The Right to Treatment," 1971, 23 Ala.L.Rev. 623; Chambers, Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives, 1969, 70 Mich.L.Rev. 1108; Katz, The Right to Treatment—An Enchanting Legal Fiction? 1969, U.Chi.L.Rev. 755; Drake, Enforcing the Right to Treatment: Wyatt v. Stickney, 1972, 10 Am.Crim.L.Rev. 587; Morris, "Criminality" and the Right to

relevant to, although not squarely in point with, the issue.[13] The idea has been current at least since 1960, since the publication in the May 1960 issue of the American Bar Association Journal of an article by Dr. Morton Birnbaum, a forensic medical doctor now generally credited with being the father of the idea of a right to treatment.[14] The A.B.A. Journal editorially endorsed the idea shortly after the publication of Dr. Birnbaum's article.[15]

We hold that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.

In reaching this result, we begin by noting the indisputable fact that civil commitment entails a "massive curtailment of liberty" in the constitutional sense. Humphrey v. Cady, 1972, 405 U.S. 504, 509, 92 S.Ct. 1048, 31 L.Ed.2d 394. The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary. Indeed, civil commitment, because it is for an indefinite term, may in some ways involve a more serious abridgement of personal freedom than imprisonment for commission of a crime usually does. Civil commitment involves stigmatizing the affected individuals, and the stigma attached, though in theory less severe than the stigma attached to criminal conviction, may in reality be as severe, or more so.[16] Since civil commitment involves deprivations of

Treatment, 1969, U.Chi.L.Rev. 784; Note, The Nascent Right to Treatment, 1967, 53 Va.L.Rev. 1134; Note, Civil Restraint, Mental Illness, and the Right to Treatment, 1967, 77 Yale L.J. 87; 80 Harv.L.Rev. 898 (1967).

13. See cases cited at nn. 23–44 *infra*.

14. Birnbaum, The Right to Treatment, 1960, 46 A.B.A.J. 499.

15. Editorial, A New Right, 1960, 46 A.B.A.J. 516.

16. On the recognition that stigmatization constitutes a deprivation of liberty in the constitutional sense, see Board of Regents v. Roth, 1972, 408 U.S. 564, 573, 92 S.Ct. 2701, 33 L.Ed.2d 548, 558–559.

liberty of the kind with which the due process clause is frequently concerned, that clause has the major role in regulating government actions in this area.

Beyond this, the conclusion that the due process clause guarantees a right to treatment rests upon a two-part theory. The first part begins with the fundamental, and all but universally accepted, proposition that "any nontrivial governmental abridgement of [any] freedom [which is part of the 'liberty' the Fourteenth Amendment says shall not be denied without due process of law] must be justified in terms of some 'permissible governmental goal.'" Tribe, Foreword—Toward a Model of Roles in the Due Process of Life and Law, 86 Harv.L.Rev. 1, 17 (1973). Once this "fairly sweeping concept of substantive due process" is assumed, *id.* at 5 n. 26,[17] the next step is to ask precisely what government interests justify the massive abridgement of liberty civil commitment entails. Typically, three distinct grounds for civil commitment are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care", "custody", or "supervision". Jackson v. Indiana, 1972, 406 U.S. 715, 737, 92 S.Ct. 1845, 32 L.Ed.2d 435; see Note, Civil Commitment of the Mentally Ill: Theories and Procedures, 1966, 79 Harv.L.Rev. 1288, 1289–97; Note, 1967, The Nascent Right to Treatment, 53 Va.L.Rev. 1134, 1138–39.[18] It is analytically useful to conceive of these grounds as falling into two categories; one a

17. *See also* Ely, The Wages of Crying Wolf: A Comment on Roe v. Wade, 1973, 82 Yale L.J. 920, 935 & n. 91; Roe v. Wade, 1973, 410 U.S. 113, 172–173, 93 S.Ct. 705, 35 L.Ed.2d 147 (Rehnquist, J., dissenting); Doe v. Bolton, 1973, 410 U.S. 179, 223, 93 S.Ct. 739, 35 L.Ed.2d 201 (White, J., dissenting).

18. In *Jackson*, the Supreme Court, relying upon an American Bar Foundation study, found that in nine states the sole criterion for involuntary commitment was the danger to self or others; that in 18 other states the patient's need for care or treatment was an alternative basis; that the need for care or treatment was the sole basis in six other states; and a few states had no statutory criteria at all and "presumably le[ft] the determination to judicial discretion". 406 U.S. at 737 n. 19, citing American Bar Foundation, The Mentally Disabled and the Law (rev. ed. 1971) at 36–49.

"police power" rationale for confinement, the other a "*parens patriae*" rationale.[19] Danger to others is a "police power" rationale; need for care or treatment a "*parens patriae*" rationale. Danger to self combines elements of both.

The key point of the first part of the theory of a due process right to treatment is that where, as in Donaldson's case, the rationale for confinement is the "*parens patriae*" rationale that the patient is in need of treatment, the due process clause requires that minimally adequate treatment be in fact provided. This in turn requires that, at least for the nondangerous patient, constitutionally minimum standards of treatment be established and enforced. As Judge Johnson expressed in the *Wyatt* case: "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." Wyatt v. Stickney, *supra*, 325 F.Supp. at 785. Or as Justice Cutter, speaking for the Supreme Judicial Court of Massachusetts, put it: "Confinement of mentally ill persons, not found guilty of crime, without affording them reasonable treatment also raises serious questions of deprivation of liberty without due process of law. As we said in the *Page* case [citation omitted], of a statute permitting comparable confinement, 'to be sustained as a nonpenal statute . . . it is necessary that the remedial aspect of confinement . . . have foundation in fact.'" Nason v. Superintendent, Bridgewater Hospital, 1968, 353 Mass. 604, 612, 233 N.E.2d 908, 913. This key step in the theory also draws considerable support from, if indeed it is not compelled by, the Supreme Court's recent decision in Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435. In *Jackson*, the Supreme Court established the rule that "[a]t the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purposes for which the individual is

19. See Note, The Nascent Right to Treatment, 1967, 53 Va.L.Rev. 1134, 1138–39.

committed". 406 U.S. at 738.[20] If the "purpose" of commitment is treatment, and treatment is not provided, then the "nature" of the commitment bears no "reasonable relation" to its "purpose", and the constitutional rule of *Jackson* is violated.

[3, 4] This much represents the first part of the theory of a due process right to treatment; persons committed under what we have termed a *parens patriae* ground for commitment must be given treatment lest the involuntary commitment amount to an arbitrary exercise of government power proscribed by the due process clause. The second part of the theory draws no distinctions between persons committed under "*parens patriae*" rationales and those committed under "police power" rationales. This part begins with the recognition that, under our system of justice, long-term detention is, as a matter of due process, generally permitted only when an individual is (1) proved, in a proceeding subject to the rigorous constitutional limitations of the due process clause of the fourteenth amendment and the Bill of Rights, (2) to have committed a *specific act* defined as an offense against the state. See Powell v. Texas, 1968, 392 U.S. 514, 533, 542–543, 88 S.Ct. 2145, 20 L.Ed.2d 1254 (Black, J., concurring). Moreover, detention, under the criminal process, is usually allowed only for a period of time explicitly fixed by the prisoner's

20. *Jackson* involved a mentally defective deaf mute who was committed after the court determined that he was incompetent to stand trial. Since the mental and physical defects which were the cause of his inability were not susceptible to treatment and not likely to improve during his confinement, it was unlikely that he would ever become competent to stand trial. In the circumstances, the Supreme Court held that its rule that "the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed" permitted the state to confine Jackson under the provisions for the commitment of those found incompetent to stand trial only for "the reasonable period of time necessary to determine whether there is a substantial probability that he will attain that capacity [to stand trial] in the foreseeable future". It held further that even if it were determined that he was likely to become able to stand trial, "his continued commitment [would have to be] justified by progress toward that goal". 406 U.S. at 738.

sentence. The second part of the theory of a due process right to treatment is based on the principle that when the three central limitations on the government's power to detain—that detention be in retribution for a specific offense; that it be limited to a fixed term; and that it be permitted after a proceeding where fundamental procedural safeguards are observed—are absent, there must be a *quid pro quo* extended by the government to justify confinement.[21] And the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment, or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary.[22]

21. One theory is that commitment pursuant to civil statutes generally lacks the procedural safeguards afforded those charged with criminal offense. The constitutional justification for this abridgment of *procedural rights* is that the purpose of commitment is treatment. (Emphasis supplied).

Welsch v. Likins, No. 4-72-Civ. 451, D.Minn., Feb. 15, 1974, — F.Supp. — at —. *See also* Inmates of Boys' Training School v. Affleck, D.R.I.1972, 346 F.Supp. 1354, 1368; Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451, 453 (Bazelon, C. J.); Note, Civil Restraint, Mental Illness, and the Right to Treatment, 1967, 77 Yale L.J. 87, 90-91, 102-03 & nn. 62-63.

22. Adequate and effective treatment is constitutionally required because, absent treatment, the hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense."

Wyatt v. Stickney, M.D.Ala.1971, 325 F.Supp. 781, 784, quoting Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (Fahy, J., concurring). *See also* cases cited in nn. 23 24 *infra*.

Of the various formulations of this "*quid pro quo*" theory we have found, perhaps the most successful is that made by Professor Nicholas Kittrie, writing specifically about confinement of juveniles, but articulating a theory equally applicable to civil commitment of mentally ill persons:

> Our society has increasingly divested certain groups from the traditional criminal justice court and, acting under its asserted role of *parens patriae*, substituted new therapeutic controls.
>
> • • • • • • • • • •
>
> A new concept of substantive due process is evolving in [this] therapeutic realm. This concept is founded upon a recognition of the concurrency between the state's exercise of sanctioning powers and its assumption of the duties of social responsibility. Its implication is that effective treatment must be the *quid pro quo* for society's right to exercise its *parens patriae* controls. Whether specifically recognized by statutory enactment or implicitly derived from the constitutional requirements of due process, the right to treatment exists.

Kittrie, Can the Right to Treatment Remedy the Ills of the Juvenile Process? 1969, 57 Geo.L.J. 851-52, 870.

This second part of the theory draws a wide range of support from a variety of precedents. The relevant cases have arisen in five major procedural contexts.

The earliest group of relevant cases consists of cases decided on habeas corpus petitions brought by citizens held under provisions for various kinds of "nonpenal" confinement, who were being held in correctional facilities for prisoners convicted of crimes. These cases uniformly held that, where detention is "nonpenal" in theory, the very least that is required is that the persons be confined in a facility other than a prison.[23]

Later cases expand the view of these cases by holding not only that persons held under provisions for "nonpenal" confinement be held elsewhere than in a prison, but that they must be held in places where the conditions are *actually* therapeutic.[24]

The third line of relevant cases are those where the constitutionality of various modern "nonpenal" statutes—notably sex-offender and defective-delinquent statutes—provide for the confinement of habitual criminal offenders to protect

23. Benton v. Reid, 1956, 98 U.S.App.D.C. 27, 231 F.2d 780; Commonwealth v. Page, 1958, 339 Mass. 313, 159 N.E.2d 82; In re Maddox, 1958, 351 Mich. 358, 88 N.W.2d 470; *cf.* Miller v. Overholser, 1953, 92 U.S.App.D.C. 110, 206 F.2d 415.

24. But this mandatory commitment provision rests upon a supposition, namely, the necessity for treatment of the mental condition which led to the acquittal by reason of insanity. And this necessity for treatment presupposes in turn that treatment will be accorded.

Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943, 950 (Fahy, J., concurring), quoted with approval, Darnell v. Cameron, 1965, 121 U.S.App.D.C. 58, 348 F.2d 64, 67-68, (Bazelon, C. J.); Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, 517, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Commonwealth v. Page, 1959, 339 Mass. 313, 317, 159 N.E.2d 82, 85.

society and to provide rehabilitative care. The decisions have upheld such statutes, but the courts have usually added the proviso that the constitutionality of the statute is conditioned upon the *realization* of the statutory promise of rehabilitative treatment.[25]

The fourth set of cases, highlighted by Rouse v. Cameron [26] and Nason v. Superintendent of Bridgewater State Hospital,[27] consists of cases where individuals under confinement have brought habeas corpus petitions challenging their confinement on the ground that they were not receiving treatment. This is a diverse group of cases; in most of them, the challenge to confinement for lack of treatment has been combined with challenges brought on other grounds, and often the other grounds are the subject of the decisions. Among these cases,

25. For those in the category [of defective delinquents] it [the defective delinquents statute] would substitute psychiatric treatment for punishment in the conventional sense and would free them from confinement, not when they have "paid their debt to society," but when they have been sufficiently cured to make it reasonably safe to release them. With this humanitarian and progressive approach to the problem no person who has deplored the inadequacies of conventional penological practices can complain. But a statute though "fair on its face and impartial in appearance" may be fraught with the possibility of abuse in that if not administered in the spirit in which it is conceived it can become a mere device for warehousing the obnoxious and antisocial elements of society. . . . *Deficiencies in staff, facilities, and finances would undermine the efficacy of the Institution and the justification for the law, and ultimately the constitutionality of its application.* [Footnotes omitted]
Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, 517, cert. dismissed as improvidently granted sub nom. Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791 (emphasis supplied). *See also* Davy v. Sullivan, M.D.Ala.1973, 354 F.Supp. 1320, (sex offender statute) (three-judge court).

26. 1966, 125 U.S.App.D.C. 366, 373 F.2d 451 (Bazelon, C. J.) The District of Columbia Circuit has reaffirmed its *Rouse* holding on numerous occasions. See, *e. g.*, In re Curry, 1971, 147 U.S.App.D.C. 28, 452 F.2d 1360; Covington v. Harris, 1969, 136 U.S.App.D.C. 35, 419 F.2d 617; Tribby v. Cameron, 1967, 126 U.S.App.D.C. 327, 379 F.2d 104; Dobson v. Cameron, 127 U.S.App.D.C. 324, 383 F.2d 519; Millard v. Cameron, 1966, 125 U.S.App.D.C. 383, 373 F.2d 468.

27. 353 Mass. 604, 233 N.E.2d 908 (1968) (Cutter, J.).

however, we have found none where any court has declared that no right to treatment exists, and we have found none explicitly recognizing a *constitutional* right to treatment. When they hold that there is a right to treatment, the cases usually either rest on statutory grounds, or are ambiguous as to whether they are resting upon statutory or constitutional grounds.[28] But in all cases, the courts have at least sustained the right of a petitioner to a hearing to develop the facts supporting his claim that he is not receiving treatment.[29]

Fifth, and last, among the groups of cases is the spate of recent cases brought as class actions in federal court, seeking broad forms of injunctive and declaratory relief requiring that adequate treatment be provided in state-run facilities. The cases have included attacks on conditions in many types of facilities—including facilities for the mentally ill,[30] the mentally retarded,[31] juvenile delinquents [32] or nondelinquent juveniles held as being "persons in need of supervision".[33]

28. *But see* Stachulak v. Coughlin, N.D.Ill.1973, 364 F.Supp. 686, a case of this kind, citing *Wyatt* and holding there is a constitutional right to treatment.

29. *E. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394 (characterizing committed sex offender's claim that he was not receiving treatment a "substantial constitutional claim", and remanding for a hearing on, inter alia, that issue).

30. See cases cited in note 9 *supra*.

31. Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 387; Welsch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, — F.Supp. —. *Contra*, New York State Ass'n for Retarded Children, Inc. v. Rockefeller, E.D.N.Y.1973, 357 F.Supp. 752.

32. Nelson v. Heyne, 7 Cir. 1974, 491 F.2d 352, aff'g N.D.Ind.1972, 355 F.Supp. 451; Inmates of Boys' Training School v. Affleck, D.R.I.1972, 346 F.Supp. 1354; Morales v. Turman, E.D.Tex.1973, 364 F.Supp. 166.

33. Martarella v. Kelley, S.D.N.Y.1972, 349 F.Supp. 575, enforced, 359 F.Supp. 478.
The closest the Supreme Court has come to speaking directly on the second, more important part of the due process right to treatment theory we articulate, came in In re Gault, 1967, 387 U.S. 1, 22

Taken together, these five sets of cases constitute a near unanimous recognition that governments must afford a *quid pro quo* when they confine citizens in circumstances where the conventional limitations of the criminal process are inapplicable. These five groups include cases decided by all levels of courts—the Supreme Court,[34] the courts of appeals,[35] the federal district courts,[36] and the state courts.[37] One or another of them concerns each of the major forms of "nonpenal confinement: from those with a heavy police power emphasis, such as

n. 30, 87 S.Ct. 1428, 18 L.Ed.2d 527, in which the Court, discussing the context of juvenile confinement, wrote:

> While we are concerned only with procedure before the juvenile court in this case, it should be noted that to the extent that the special procedures for juveniles are thought to be justified by the special consideration and treatment afforded them, there is reason to doubt that juveniles always receive the benefits of such a *quid pro quo* . . . . The high rate of juvenile recidivism casts some doubt upon the adequacy of treatment afforded juveniles . . . .
>
> In fact some courts have recently indicated that appropriate treatment is essential to the validity of juvenile custody, and therefore that a juvenile may challenge the validity of his custody on the ground that he is not in fact receiving any special treatment.

34. Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435; Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; McNeil v. Director, Patuxent Institution, 1972, 407 U.S. 245, 92 S.Ct. 2083, 32 L.Ed.2d 719.

35. *E. g.*, Nelson v. Heyne, *supra* note 39; Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, *cert. dismissed as improvidently granted* sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 541.

36. *E. g.*, cases cited in nn. 9, 31–33, *supra*.

37. *E. g.*, Nason v. Superintendent, Bridgewater Hospital, 1968, 353 Mass. 604, 233 N.E.2d 908; Commonwealth v. Page, 1959, 339 Mass. 313, 159 N.E.2d 82; In re Maddox, 1958, 351 Mich. 358, 88 N.W.2d 470.

confinement of sex offenders[38] or defective delinquents,[39] of persons acquitted by reason of insanity,[40] or of persons held incompetent to stand trial;[41] those with a heavy *parens patriae* emphasis, such as confinement of the mentally retarded,[42] or of juveniles;[43] and those—such as civil commitment of the mentally ill[44]—with elements of both rationales behind them.

The appellants argue strenuously that a right to constitutionally adequate treatment should not be recognized, because such a right cannot be governed by judicially manageable or ascertainable standards. In making the argument, they rely heavily upon the Northern District of Georgia's decision in Burnham v. Department of Public Health, 1972, 349 F.Supp. 1335, 1341–1343. In *Burnham*, the district judge held that a class action seeking declaratory and injunctive relief requiring the Georgia Department of Public Health to provide treatment at Georgia mental hospitals presented a nonjusticiable controversy. He quoted Baker v. Carr, 1962, 369 U.S. 186,

38. *E. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; Davy v. Sullivan, M.D.Ala.1973, 354 F.Supp. 1320 (three-judge court); Commonwealth v. Page, 1959, 339 Mass. 313, 159 N.E.2d 82.

39. *E. g.*, Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791.

40. *E. g.*, Rouse v. Cameron, 1966, 125 U.S.App.D.C. 366, 373 F.2d 451 (Bazelon, C. J.); Darnell v. Cameron, 1965, 121 U.S.App.D.C. 58, 348 F.2d 64 (Bazelon, C. J.); Ragsdale v. Overholser, 1960, 108 U.S.App.D.C. 308, 281 F.2d 943 (Burger, J.).

41. Jackson v. Indiana, 1972, 406 U.S. 715, 92 S.Ct. 1845, 32 L.Ed.2d 435. *See also* Greenwood v. United States, 1956, 350 U.S. 366, 76 S.Ct. 410, 100 L.Ed. 412; United States v. Pardue, D.Conn.1973, 354 F.Supp. 1377; United States v. Jackson, N.D.Cal.1969, 306 F.Supp. 4.

42. *E. g.*, Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 387; Welsch v. Likins, No. 4-72-Civ. 451, D.Minn. Feb. 15, 1974, noted, 42 U.S.L.W. 1141–42.

43. Cases cited in notes 32–33.

44. Cases cited in note 9 *supra*.

198, 82 S.Ct. 691, 700, 7 L.Ed.2d 663, for the proposition that determining whether a suit was justiciable requires determining whether "the duty asserted can be judicially identified and its breach judicially determined, and whether protection for the right asserted can be judicially molded". 349 F.Supp. at 1341, quoting 369 U.S. at 198. He then cited the ambiguity of the dictionary definition of treatment, a passage from a law review article noting the fact that there are as many as forty different methods of psychotherapy,[45] and a passage from the Supreme Court's decision in Greenwood v. United States, 1956, 350 U.S. 366, 76 S.Ct. 410, 100 L.Ed. 412, concerning the "tentativeness" and "uncertainty" of "professional judgment" in the mental health field.[46] He concluded: "[T]he claimed duty (i. e. to 'adequately' or 'constitutionally treat') defies judicial identity and therefore prohibits its breach from being judicially defined." 349 F.Supp. at 1342.

The defendants' argument can be answered on two levels. First, we doubt whether, even if we were to concede that courts are incapable of formulating standards of adequate

45. Levine [M. Levine, Psychotherapy in Medical Practice] lists 40 methods of psychotherapy. Among these, he includes physical treatment, medicinal treatment, reassurance, authoritative firmness, hospitalization, ignoring of certain symptoms and attitudes, satisfaction of neurotic needs and bibliotherapy. In addition, there are physical methods of psychiatric therapy, such as the prescription of sedatives and tranquilizers, the induction of convulsions by drugs and electricity, and brain surgery. *Obviously, the term "psychiatric treatment" covers everything that may be done under medical auspices—and more.*

If mental treatment is all the things Levine and others tell us it is, how are we to determine whether or not patients in mental hospitals receive adequate amounts of it?

Szasz, The Right to Psychiatric Treatment: Rhetoric and Reality, 1969, 57 Geo.L.J. 740, 741.

46. . . . [T]heir [two court-appointed psychiatrists] testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment.

Greenwood v. United States, 1956, 350 U.S. 366, 375, 76 S.Ct. 410, 415, 100 L.Ed. 412.

treatment in the abstract, that we could or should for that reason alone hold that no right to treatment can be recognized or enforced. There will be cases—and the case at bar is one—where it will be possible to make determination whether a given individual has been denied his right to treatment without formulating in the abstract what constitutes "adequate" treatment. In this case, the jury properly could have concluded that Donaldson had been denied his rights simply by comparing the treatment he received while he was under Gumanis's and O'Connor's care with that he received while under Hanenson's care; or it could have concluded that Donaldson's rights had been violated on the basis of the evidence that the defendants obstructed his release even though they knew he was receiving no treatment. Neither judgment required any *a priori* determination of what constitutes or would have constituted adequate treatment, and of course no such determination was made.

We do not, however, concede that determining what constitutes adequate treatment is beyond the competence of the judiciary. In deciding in individual cases whether treatment is adequate, there are a number of devices open to the courts, as Judge Bazelon noted in discussing the implementation of the statutory right to treatment in the landmark case of Rouse v. Cameron:

> But lack of finality [of professional judgment] cannot relieve the court of its duty to render an informed decision. Counsel for the patient and the government can be helpful in presenting pertinent data concerning standards for mental care, and, particularly when the patient is indigent and cannot present experts of his own, the court may appoint independent experts. Assistance might be obtained from such sources as the American Psychiatric Association, which has published standards and is continually engaged in studying the problems of mental care. The court could also consider inviting the psychiatric and legal communities to

establish procedures by which expert assistance can be best provided. [Footnotes omitted].

373 F.2d at 457. There are by now many cases where courts have undertaken to determine whether treatment in an individual case is adequate or have ordered that determination to be made by a trial court.[47] Even in cases like *Wyatt* and *Burnham*, when courts are asked to undertake the more difficult task of fashioning institution-wide standards of adequacy, the task should not be beyond them. The experience of the *Wyatt* case bears this out. In *Wyatt*, agreement was reached among the parties on almost all of the minimum standards for adequate treatment ordered by the district court, and the defendants joined in submitting the standards to the district court. These stipulated standards were supported and supplemented by testimony from numerous expert witnesses. Moreover, there was a striking degree of consensus among the experts, including the experts presented by the defendants, as to the minimum standards for adequate treatment. The standards developed have not been challenged by the defendants in the appeal now pending before this Court. See Wyatt v. Stickney, M.D.Ala.1972, 344 F.Supp. 373, 375–376.

In summary, we hold that where a nondangerous patient is involuntarily civilly committed to a state mental hospital, the only constitutionally permissible purpose of confinement is to

47. See, *e. g.*, Humphrey v. Cady, 1972, 405 U.S. 504, 92 S.Ct. 1048, 31 L.Ed.2d 394; In re Curry, 1971, 147 U.S.App.D.C. 28, 452 F.2d 1360; United States v. Waters, 1970, 141 U.S.App.D.C. 289, 437 F.2d 722; Dobson v. Cameron, 1967, 127 U.S.App.D.C. 324, 383 F.2d 519; Tribby v. Cameron, 126 U.S.App.D.C. 327, 379 F.2d 104; Millard v. Cameron, 1966, 125 U.S.App.D.C. 383, 373 F.2d 468; Sas v. Maryland, 4 Cir. 1964, 334 F.2d 506, remanding, D.Md., 1969, 295 F.Supp. 389, aff'd sub nom., Tippett v. Maryland, 1971, 436 F.2d 1153, cert. dismissed as improvidently granted sub nom., Murel v. Baltimore City Crim. Ct., 1972, 407 U.S. 355, 92 S.Ct. 2091, 32 L.Ed.2d 791; Dixon v. Atty. Gen'l of Pennsylvania, M.D.Pa.1971, 325 F.Supp. 966 (three-judge); In re Jones, D.D.C.1972, 338 F.Supp. 428; Clatterbuck v. Harris, D.D.C.1968, 295 F.Supp. 84; Nason v. Supt. of Bridgewater State Hospital, 1968, 353 Mass. 604, 233 N.E.2d 908.

provide treatment, and that such a patient has a constitutional right to such treatment as will help him to be cured or to improve his mental condition. We hold that the district court did not err in so instructing the jury.

III.

[5] Gumanis and O'Connor join in contending that the evidence at trial did not permit the jury to find that they acted in bad faith, and that therefore they cannot be held personally liable for Donaldson's injuries or the deprivations of his constitutional rights. Gumanis's arguments concern primarily his role in deciding whether Donaldson could or should be released. He asserts that he acted throughout in good faith and in the reasonable belief that Donaldson was mentally ill and required further confinement. O'Connor's argument is directed not only toward his acts affecting the decision whether to release, but also to the entirety of his conduct while Donaldson was held at Florida State. O'Connor argues that both he and Gumanis did the best they could with available resources, and therefore should not be held personally liable for whatever was done to Donaldson. He cites in his brief the various limitations of staff and funds available to the state psychiatrists at Florida State, the difficulties hospital administrators have had in winning approval of their budgets from the state legislatures, and similar matters; and he argues, on that basis, that the denial of whatever right to treatment Donaldson had was the product of the actions of the legislature and of the realities of the budgetary situation, and not of the actions of the state psychiatrists to whose care Donaldson was entrusted.

We find the appellants' objection, in all of its various forms, without merit.

The trial judge instructed the jury:

> The defendants in this action rely on the defense that they acted in good faith. Simply put, defendants contend they in good faith believed it was necessary to detain

plaintiff in the Florida State Hospital for treatment for the length of time he was so confined. If the jury should believe from a preponderance of the evidence that defendants reasonably believed in good faith the detention of plaintiff was proper for the length of time he was confined then a verdict for defendants should be entered even though the jury may find the detention to have been unlawful.

However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify plaintiff's confinement in the Florida State Hospital. As a corollary plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual deprivation of constitutional rights or other rights guaranteed by law.

The defendants did not object to this instruction, and do not challenge its correctness here.[48] The instruction was proper, and that there was sufficient evidence to support a jury finding that the defendants did not act at all times in a good faith and reasonable belief that Donaldson needed continued confinement and that continued confinement was lawful. In effect, the jury found, on the facts, that Donaldson's right to treatment was denied not, or not only by the limitations of funds and staff and resources under which the hospital operated, but also by the actions of Gumanis and O'Connor themselves.

We are "duty bound to accept all evidence in favor of the verdict as true and to give such evidence the benefit of all permissible inferences that would help sustain the jury's decision". Little v. Green, 5 Cir. 1970, 428 F.2d 1061, cert. denied, 400 U.S. 964, 91 S.Ct. 366, 27 L.Ed.2d 384; Grey v. First National Bank, 5 Cir. 1968, 393 F.2d 371, 381. We hold therefore that the evidence supported the jury's finding that the defendants did not act in good faith.

48. Dowsey v. Wilkins, 5 Cir. 1972, 467 F.2d 1022, 1025–1026.

IV.

The first contention made by Gumanis alone is that the Northern District of Florida's jury selection plan operated to abridge his right to a jury trial under the seventh amendment and under 28 U.S.C. §§ 1861, 1862, by permitting the "systematic exclusion" of physicians from the jury rolls. Gumanis raised his objection to the composition of the jury on the first day of the trial, but after the jury had been impanelled and sworn. The Northern District selection plan allows certain specified classes of person, including "actively engaged members of the clergy" and "actively practicing attorneys, physicians, and dentists, and registered nurses", to be excused from jury duty if they so desire. The authority for these exceptions is an express provision of the Jury Selection and Service Act. 28 U.S.C. § 1863(b)(5) provides that a jury selection plan shall "specify those groups of persons or occupational classes whose member shall, on individual request therefore be excused from jury service. . . . if the district court finds, and the plan states, that jury service by such class or group would entail undue hardship or extreme inconvenience. . . . ."

[6, 7] There is no merit to the defendant's contention. The trial court correctly held that the objection was not timely raised, since the defendants had not mentioned it until after the jury was impanelled. See Brooks v. United States, 5 Cir. 1969, 416 F.2d 1044, 1047. We also agree with his ruling that the jury selection plan was in compliance with the statute.

V.

Gumanis next objects to the trial court's refusal to instruct the jury that Donaldson's claim was barred by the statute of limitations.[49] This contention is premised upon the fact that Donaldson was taken out of his care April 18, 1967, more than four years before the filing of the First Amended Complaint in this case, and about five years before the complaint was amended to add Gumanis as a defendant.

Since there is no statute of limitations provided under § 1983, federal courts adopt the statute of limitations of the state where the action arose,[50] and apply the "resemblance test" to decide which state statute is an appropriate one to apply.[51] In this case, the parties agree that the limitation period should be taken from one of three state statutes: the two-year statute applicable to both false imprisonment actions and to actions for medical malpractice; or the three-year statute applicable to actions upon liabilities created by statute; or the four-year statute applicable to miscellaneous actions not specifically provided for elsewhere in the Florida statute of limitations chapter.[52] Gumanis argues that it is irrelevant which of these 3 periods we apply, since even if the

49. The instruction in question read:
You are instructed that the statute of limitations for the wrongs alleged in the complaint are for the period of four (4) years, and that the defendants should not be held accountable for any damages which occurred from wrongs occurring prior to the four (4) year period preceding the complaint.
Donaldson argues that the defendants' objection to the trial judge's refusal to give this instruction is not properly before this Court, again because no objection was made to the trial judge's failure to give the instruction either at the charge conference or after the charge was read to the jury. See note 8 *supra*. Again, however, defendants' pretrial brief advised the court of the defendants' position, and again we hold that that sufficed to excuse the failure to object. See note 8 *supra*.

50. Campbell v. Haverhill, 1895, 155 U.S. 610, 15 S.Ct. 217, 39 L.Ed. 280.

51. See, *e. g.*, Smith v. Cremins, 9 Cir. 1962, 308 F.2d 187.

52. Fla.Stat. § 95.11(4), (5)(a), (6), F.S.A.

longest, the four-year statute, is applied, the period of limitations had elapsed by the time Gumanis was added as a defendant in this suit. Donaldson agrees that it is irrelevant which statute is chosen, since the limitation did not begin to run until July 31, 1971, the date Donaldson was released from the hospital. Donaldson therefore argues that the suit was timely brought, even if the two-year limitation period applies.

[8–10] We agree with Donaldson that the limitation period, be it two, three, or four years, did not begin to run until July 31; Donaldson's cause of action did not accrue until that time. When a tort involves continuing injury, the cause of action accrues, and the limitation period begins to run, at the time the tortious conduct ceases. See, *e. g.*, Fowkes v. Pennsylvania R. R. Co., 3 Cir. 1959, 264 F.2d 397. In the case of false imprisonment, the tort action this case most resembles, the cause of action does not accrue until the release of the imprisoned party.[53]

[11] We have found no Florida decision addressing the question when a cause of action for false imprisonment accrues. But in a § 1983 suit, even though a state statute is applied, the question when a federal cause of action *accrues* is a matter of federal, not state law.[54] The state statute is applied in the first place not as a matter of legal compulsion, but merely as a matter of convenience; there is no other period of limitation available.[55] We hold that in a case such as

53. See, *e. g.*, Bronaugh v. Harding Hospital, Inc., 1958, 12 Ohio App.2d 110, 231 N.E.2d 487; Mobley v. Broome, 1958, 248 N.C. 54, 102 S.E.2d 407; Matovina v. Hult, 1955, 125 Ind.App. 236, 244, 123 N.E.2d 893; Bellflower v. Blackshere, Okl.1955, 281 P.2d 423, 425; Oosterwyk v. Bucholtz, 1947, 250 Wis. 521, 525, 27 N.W.2d 361; Jedzierowski v. Jordan, 1961, 157 Me. 352, 172 A.2d 636.

54. See, *e. g.*, Rawlings v. Ray, 1941, 312 U.S. 96, 61 S.Ct. 473, 85 L.Ed. 605; Cope v. Anderson, 1947, 331 U.S. 461, 67 S.Ct. 1340, 91 L.Ed. 1602; Sandidge v. Rogers, S.D.Ind.1958, 167 F.Supp. 553, 556; 2 Moore's Federal Practice ' 3.07(2) at 750.

55. See McAllister v. Magnolia Petroleum Co., 1958, 357 U.S. 221, 228-230, 78 S.Ct. 1201, 2 L.Ed.2d 1272 (Brennan, J., concurring); 2 Moore's Federal Practice ' 3.07(2).

this one, where a tort causing continuing injury is alleged, a patient's cause of action does not accrue until the date of his release.

VI.

[12] Gumanis next contends[56] that the district court erred in refusing to instruct the jury that he and the other defendants were entitled to a defense of quasi-judicial immunity under the Civil Rights Acts. At issue is defendant's proposed instruction number 11, which read:[57] "If you find that the defendants were operating in a quasi-judicial function, in that they, under state law, were making a judgment as to whether or not plaintiff should be released, defendants are immune from liability under the Civil Rights Act."

Gumanis relies primarily upon three Ninth Circuit cases. The first and most important is Hoffman v. Halden, 1969, 268 F.2d 280, in which the Ninth Circuit held that the superintendent of a state mental hospital, who allegedly had wrongfully detained a patient committed under a valid judicial commitment order, was immune from liability. The superintendent was empowered to release the patient when, in his own judgment, he found the patient no longer in need of confinement. The Court held that because he had been exercising a "discretionary" function, the Superintendent was immune from liability. The other two Ninth Circuit cases, Silver v. Dickson, 1968, 403 F.2d 642, and Keeton v. Procunier, 1971, 468 F.2d 810, held that members of state parole boards are immune from § 1983 liability, on the ground that the threat of liability would "exert a restricting influence on the overall functioning of the agency". *Silver*, 403 F.2d at 643.

56. Once again, Donaldson argues that the objection to the refusal to give the instruction is not properly before the Court. See notes 8, 49 *supra*. Once again, we hold that the trial judge was sufficiently apprised of the defendants' objections for us to consider the objection as having been preserved. See notes 8, 49 *supra*.

57. The full instruction is quoted in part III *supra*.

[13] Gumanis's argument is essentially that he is entitled to the defense, available to state officials in most common law jurisdictions, of absolute immunity for acts done in the performance of a "discretionary"—as opposed to a "ministerial"—function. See, *e. g.*, Barr v. Matteo, 1959, 360 U.S. 564, 79 S.Ct. 1335, 3 L.Ed.2d 1434 (immunity for federal officials as a matter of federal common law). For discussions of the common law rule, see Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 857 861 (Rives, J.); Anderson v. Nosser, 5 Cir. 1971, 438 F.2d 183, 198 200 (Goldberg, J.); modified en banc on other grounds, 1972, 456 F.2d 835; Carter v. Carlson, 1971, 144 U.S.App.D.C. 388, 447 F.2d 358, 361 365; 2 F. Harper & F. James, The Law of Torts § 29.10 at 1638 46 (1956). We must reject Gumanis's argument, however, because we have consistently held that the full range of officials immunities available at common law do not apply in actions brought under § 1983. Roberts v. Williams, 5 Cir. 1972, 456 F.2d 819, 830; *Anderson, supra*, 438 F.2d at 201; *Norton, supra*, 332 F.2d at 860 861 (dictum). In taking this position we have been joined by all the other circuits that have considered the question. *Carter, supra*, 447 F.2d at 365; Dale v. Hahn, 2 Cir. 1971, 440 F.2d 633; Kletschka v. Driver, 2 Cir. 1969, 411 F.2d 436, 448; Jobson v. Henne, 2 Cir. 1966, 355 F.2d 129, 133-134; McLaughlin v. Tilendis, 7 Cir. 1968, 398 F.2d 287; Donovan v. Reinbold, 9 Cir. 1970, 433 F.2d 738.

Official immunity has been restricted under § 1983, because that provision is directed at actions "under color of any statute, ordinance, regulation, custom, or usage of any State or Territory", and provides that "every person" subjecting another to a deprivation of constitutional rights shall be liable. See Francis v. Lyman, 1 Cir. 1954, 216 F.2d 583, 587; *Jobson, supra*, 355 F.2d at 133; *Anderson, supra*, 438 F.2d at 201; *Hoffman, supra*, 268 F.2d at 290. It has been the view of the courts that recognizing broad judicial immunities "would prac-

tically constitute a judicial repeal" of § 1983, since state officers are likely to be the primary persons found acting "under color of" law. *Hoffman, supra*, at 300; *Jobson, supra*, 355 F.2d at 134. Accordingly, the courts have repudiated what the district court for the District of Nevada has called the "discretionary act test" for determining when official immunity is appropriate in § 1983 cases. Adamian v. University of Nevada, 1973, 359 F.Supp. 825, 834. Instead, we and other courts have applied what the *Adamian* court called the "good faith for qualified governmental immunity" test, allowing immunity when (1) the officer's acts were discretionary; *and* (2) the officer was acting in good faith. Here, as noted above, the trial judge instructed the jury to find for the defendants if it found the defendants acted in good faith; and, again as noted above, the defendants have not challenged the propriety or phrasing of this instruction. That instruction was all that was required by this Court's version of the doctrine of "quasi-judicial" or "official" immunity from Civil Rights Act liability.[58]

58. It is appropriate to say in this context that we do not view the *Hoffman*, *Silver*, and *Keeton* cases as sound authority for a contrary result. The Ninth Circuit has made it clear that Hoffman and Silver do not "stand for the broad principle that all public officials are immune from Civil Rights Act liability if their acts were discretionary and done within the scope of their official duties". Donovan v. Reinbold, 9 Cir. 1970, 433 F.2d 738, 744. The Second Circuit had earlier stated its view that it would have disapproved the *Hoffman* decision if that decision had to be read to mean that "all subordinate state officials should be granted an immunity for all discretionary acts". *Jobson, supra*, 355 F.2d at 134 n. 11. And we ourselves have already once stated our view that *Hoffman* represented a "questionabl[e] resol[ution]" of the problem of official immunity under the Civil Rights Act. Norton v. McShane, 5 Cir. 1964, 332 F.2d 855, 861 n. 9, (Rives, J.). To the extent that *Hoffman*, by implying that state mental health officials should enjoy some form of "quasi-judicial immunity", is read as authority for a result contrary to the one we reach here, we decline to follow it. We rely instead on *Dale* and *Jobson*, where the Second Circuit held state psychiatrists and mental hospital officials were not entitled to immunity under § 1983.

VII.

[14] The remainder of the objections Gumanis raises pose little difficulty. Gumanis contends that the trial judge erred in allowing the jury to award punitive damages. The objection is without merit. The trial judge instructed the jury that it could award punitive damages if it found that the defendants had acted "maliciously", "wantonly", or "oppressively". The instruction was proper as a matter of law, and there was ample evidence, some of it recited in our statement of facts above, to support a jury finding that the defendants' acts were "malicious", "wanton", or "oppressive".

[15] Gumanis argues that Donaldson's failure to receive treatment was a result largely of his own refusal, on religious grounds, to accept certain forms of treatment, particularly medication and electroshock treatments, and his failure to petition for restoration of his competency under Fla.Statutes § 394.22, F.S.A. Neither argument has any merit. As for Donaldson's refusal of forms of treatment, the trial judge instructed the jury: "You are instructed that if Plaintiff through his own actions contributed to the withholding of a particular form of treatment, that Plaintiff is not entitled to collect compensation from the Defendants for the failure to give such treatment during the particular period or periods Plaintiff refused such treatment." Gumanis did not at the trial and does not now object to this instruction. We find no reason to believe that either the verdict or the award of damages was based upon the failure to give Donaldson those forms of treatment he refused. As for his failure to petition for a restoration of his competency, the statute in question does not permit a person adjudged incompetent to petition on his own for a restoration of his competency; the petition may be instituted only by a parent, guardian, or "next friend". Donaldson cannot be held accountable for not doing what he was legally unable to do.

Finally, Gumanis contends that "the cumulative effect of certain errors and irregularities during the course of the trial

was such as to significantly undermine the fairness of the trial itself". We have considered these alleged errors too, and find no merit to any one of them. We have also concluded, upon a review of the record, that cumulatively they did not affect the fairness of the trial to any appreciable extent.

The judgment of the district court is

Affirmed.

Adm. Office, U.S. Courts—West Publishing Company, Saint Paul, Minn.

United States Court of Appeals

FOR THE FIFTH CIRCUIT

October Term, 1973

No. 73-1843

D. C. Docket No. CA 1693

KENNETH DONALDSON,
Plaintiff-Appellee,

versus

J.B. O'CONNOR, M.D. and JOHN GUMANIS, M.D.,
Defendants-Appellants.

Appeals from the United States District Court for the
Northern District of Florida

Before RIVES, WISDOM and MORGAN, Circuit Judges.

JUDGMENT

This cause came on to be heard on the transcript of the record from the United States District Court for the Northern District of Florida, and was argued by counsel;

ON CONSIDERATION WHEREOF, It is now here ordered and adjudged by this Court that the judgment of the said District Court in this cause be, and the same is hereby, affirmed.

April 26, 1974

Issued as Mandate:

BEST COPY AVAILABLE

Supreme Court, U. S.
F I L E D
AUG 30 1974
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1973

No. 74-8

J. B. O'CONNOR, M.D.,

Petitioner,

—v.—

KENNETH DONALDSON,

Respondent.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRUCE J. ENNIS
84 Fifth Avenue
New York, New York 10011

EUGENE DUBOSE
357 East Chicago Ave.
Chicago, Illinois 60611

GEORGE DEAN
P. O. Box 248
Destin, Florida 37541

MORTON BIRNBAUM
225 Tompkins Avenue
Brooklyn, New York 11216

Attorneys for Respondent

INDEX

PAGE

Questions Presented 1

Statement of the Case 2

ARGUMENT:

I. This Case Does Not Present the Traditional Reasons for Granting Certiorari 4

A. Right to Treatment 4

B. Waiver 7

CONCLUSION 8

TABLE OF AUTHORITIES

Cases:

Covey v. Town of Somers, 351 U.S. 141 (1956) 8

Greenwood v. United States, 350 U.S. 366 (1956) 6

Humphrey v. Cady, 405 U.S. 504 (1972) 6

Jackson v. Indiana, 406 U.S. 715 (1972) 5, 6

Johnson v. Zerbst, 304 U.S. 458 (1938) 8

McNeil v. Director, Patuxent Institution, 407 U.S. 245 (1972) 6

PAGE

Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974) 5

Pate v. Robinson, 383 U.S. 375 (1966) 8

Robinson v. California, 370 U.S. 660 (1962) 6
Rouse v. Cameron, 372 F.2d 541 (D.C. Cir. 1966) 5

Sas v. Maryland, 334 F.2d 506 (4th Cir. 1964), *cert. dismissed as improvidently granted sub nom.* Murel v. Baltimore City Criminal Court, 407 U.S. 355 (1972) 5

United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir.), *cert. denied,* 396 U.S. 847 (1969) 5

IN THE

Supreme Court of the United States

OCTOBER TERM, 1973

No. 74-8

J. B. O'CONNOR, M.D.,

Petitioner,

—v.—

KENNETH DONALDSON,

Respondent.

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

Questions Presented

I. Is there no evidence from which the jury could reasonably have concluded, as it did, that petitioner confined respondent against his will, knowing he was not dangerous and knowing he was not receiving treatment for his alleged mental illness?

II. Is there no evidence from which the jury could reasonably have concluded, as it did, that petitioner's acts were sufficiently malicious, wanton and oppressive to justify punitive damages?

III. Did the Court below err in ruling that a non-dangerous mental patient, not charged with any crime, has a Constitutional right either to treatment or else release?

Statement of the Case

Petitioner O'Connor, though under no statutory or judicial obligation to do so, deprived respondent Kenneth Donaldson of his liberty for fifteen years. He did so even though he knew Donaldson was not dangerous to himself or others. He did so even though he knew Donaldson was receiving only the same custodial care he would have received in a prison. And having the power and authority to release Donaldson, he blocked Donaldson's every effort to be released to the custody of responsible friends and organizations. His acts, as the jury found, were so malicious, wanton and oppressive as to justify not only compensatory damages of $17,000, but punitive damages of $5,000. His defense was that he acted in good faith and did the best he could with limited resources. The jury considered the evidence and found that was not true.

Many of the "facts" listed in the Petition for Certiorari find no support in the evidence. A more accurate and complete summary of the facts of record can be found in the unanimous opinion of the court below, 493 F.2d 507 at 510-515.

Essentially, the Court of Appeals found "ample evidence" to support the following findings of fact:

"A. The defendants unjustifiably withheld from Donaldson specific forms of treatment."

"B. The defendants recklessly failed to attend to and treat Donaldson at precisely those junctures when treatment could have most helped Donaldson recover and therefore be released."

"C. The defendants wantonly, maliciously, or oppressively blocked efforts by responsible and interested friends and organizations to have Donaldson released to their custody."

"D. The defendants continued to confine Donaldson knowing he was not dangerous, or with reckless disregard for whether he was dangerous."

"E. The defendants did not do the best they could with available resources."

Two additional facts should be noted. First, petitioner contends that he had no authority to release Donaldson until he was restored to mental health (Petition, pp. 36-37). That contention is incorrect, and finds no support in the record. To the contrary, a co-defendant, John Gumanis, M.D., confirmed at trial that a patient did not have to recover to be released on furlough or trial visit, and that such releases could be granted even though the patient was still considered to be mentally ill (Transcript of 11/27/72, p. 5). A defense witness, Dr. W. D. Rogers, director of the Florida Division of Mental Health, testified that staff psychiatrists had the authority to "release the patient to family, guardian or to some responsible person," that trial visits were quite common, and that "a large number of patients went out under the trial visit arrangement" (Transcript of 11/27/73, pp. 150-151).

Second, petitioner contends "he should be immune from damages in a situation where he was acting in good faith. . . . " (Petition, p. 40). The trial court agreed with that contention, and so instructed the jury (493 F.2d at 527). The jury found, however, that petitioner acted maliciously,

and in bad faith. Petitioner did not, in the court below, challenge the correctness of the instruction on this point, and the court below found there was "sufficient evidence" to support the jury's finding of bad faith (*id.*).

ARGUMENT

I.

This Case Does Not Present the Traditional Reasons for Granting Certiorari.

A. *Right to Treatment*

The respondent did not claim below that he had a constitutional right to treatment. He claimed, as the court below carefully noted, "that he had a constitutional right to receive treatment or to be released from the state hospital" (493 F.2d at 509).

Accordingly, petitioner was found liable in damages not for failure to provide treatment, or a certain type or level of treatment, but because he refused to release Donaldson even though he knew Donaldson was receiving *no* treatment. As the court below found, "the jury properly could have concluded . . . that the defendants obstructed his release even though they knew he was receiving no treatment" (493 F.2d at 526). That conclusion would not have required "any *a priori* determination of what constitutes or would have constituted adequate treatment, and of course no such determination was made" (*id.*).

The issue then, is not what constitutes adequate treatment, but whether a non-dangerous person can constitutionally be deprived of liberty for 15 years, during which time he is given *no* treatment.

This is, of course, an important issue. But the resolution of that issue by the decision below presents none of the traditional reasons for granting certiorari.

1. There was no dissent.

2. There is no conflict between circuits. To the contrary, decisions in the 7th, 4th and D.C. circuits, though not precisely in point, are certainly consistent with the decision of the Fifth Circuit in this case. *E.g.*, *Nelson* v. *Heyne*, 491 F.2d 352 (7th Cir. 1974); *Sas* v. *Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. dismissed as improvidently granted sub nom. Murel* v. *Baltimore City Criminal Court*, 407 U.S. 355 (1972); *Rouse* v. *Cameron*, 373 F.2d 541 (D.C. Cir. 1966). And see, *United States ex rel. Schuster* v. *Herold*, 410 F.2d 1071 (2d Cir.), *cert. denied*, 396 U.S. 847 (1969).

3. The decision below is not inconsistent with prior decisions of this Court. To the contrary, the decision below is compelled by the principles established in the prior decisions of this Court.

In *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972), for example, this Court ruled unanimously that "at the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." The state court order committing Donaldson expressly stated that he was committed for the purpose of receiving "treatment." The evidence showed, however, that "he received only the kind of subsistence level custodial care he would have received in a prison, and perhaps less psychiatric treatment than a

criminally committed inmate would have received" (493 F.2d at 512).

In short, Kenneth Donaldson, charged with no crime, was confined 15 years in an institution that was, in effect, a prison. Surely, under *Jackson*, the "nature" and "duration" of his confinement bore no reasonable relation to the purpose of confinement.*

In *Robinson* v. *California*, 370 U.S. 660 (1962), this Court made it clear that no one may constitutionally be "punished" for the "status" of being mentally ill, and equally clear that confinement of a non-dangerous person in a prison-like institution, without "treatment," constitutes punishment.

Much earlier, in *Greenwood* v. *United States*, 350 U.S. 366 (1956), this Court indicated that "indefinite" or long term hospitalization of non-dangerous persons is constitutionally impermissible. A similar view was expressed more recently in *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972).

It seems fair to conclude, on the particular facts of this case, that the decision below is not only correct, but required by the previous decisions of this Court.

There is an additional reason why certiorari should not be granted to review the existence or non-existence of a constitutional right to treatment or else release. An instruction actually proposed by petitioner, but refused by the trial court, would have authorized the jury to find a *constitutional* violation if they believed petitioner confined Donaldson, knowing he was not receiving adequate treatment (De-

* See also, *McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245 (1972).

fendants' Proposed Instruction Number 8).* There is ample evidence to support a jury verdict even under the instruction proposed by petitioner.

B. *Waiver*

Petitioner next contends that if there is a constitutional right to treatment or else release, certiorari should be granted to determine whether Donaldson "waived that right" by refusing, on occasion, certain types of treatment, namely electro-shock therapy and tranquilizing medication (Petition, p. 41).

This contention was not raised by petitioner in his brief to the court below, only by his co-defendant (493 F.2d at 531). Furthermore, the trial court, at defendants' request, instructed the jury as follows: "You are instructed that if Plaintiff through his own actions contributed to the withholding of a particular form of treatment, that Plaintiff is not entitled to collect compensation from the Defendants for the failure to give such treatment during the particular period or periods Plaintiff refused such treatment" (*id.*). Accordingly, the court below unanimously ruled that the "waiver" argument did not have "any merit" (*id.*).

Actually, that instruction was more than fair to defendants. Had Donaldson wished to challenge that instruction, he could have pointed out that it rested on the assumption that a person adjudged to be mentally incompetent can

* "If you believe that defendants, without fault of plaintiff, withheld psychiatric treatment from plaintiff, or allowed his confinement to continue knowing that he was not receiving adequate treatment, you may find that his confinement was illegal under the federal constitution and the Civil Rights Act."

knowingly and intelligently "waive" an important constitutional right. That assumption is inconsistent with the standards governing waiver annuounced in prior decisions of this Court, *E.g., Pate* v. *Robinson*, 383 U.S. 375 (1966); *Covey* v. *Town of Somers*, 351 U.S. 141 (1956); and *Johnson* v. *Zerbst*, 304 U.S. 458 (1938).

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted,

Bruce J. Ennis
84 Fifth Avenue
New York, New York 10011

Eugene DuBose
357 East Chicago Ave.
Chicago, Illinois 60611

George Dean
P. O. Box 248
Destin, Florida 37541

Morton Birnbaum
225 Tompkins Avenue
Brooklyn, New York 11216

Attorneys for Respondent

Supreme Court, U. S.
FILED
OCT 3 1974
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1973

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner,*

v.

KENNETH DONALDSON, *Respondent.*

Brief of American Psychiatric Association as Amicus Curiae in Support of the Grant of Certiorari

E. BARRETT PRETTYMAN, JR.
ALLEN R. SNYDER
HOGAN & HARTSON
815 Connecticut Ave.
Washington, D.C. 20006
Attorneys for Amicus Curiae

PRESS OF BYRON S. ADAMS PRINTING, INC., WASHINGTON, D. C.

TABLE OF CONTENTS

Page

INTEREST OF AMICUS CURIAE 1

CONSENT OF THE PARTIES 2

ARGUMENT 2

I. This Court Should Grant Certiorari Here To Affirm The Constitutional Right To Treatment 3

II. The Lower Court's Standard For Personal Liability Conflicts With The Principle Of *Pierson* v. *Ray* And Will Hamper Enforcement Of Patients' Right To Treatment 7

CONCLUSION 14

TABLE OF AUTHORITIES

CASES:

Clarke v. *Cady*, 358 F. Supp. 1156 (W.D. Wisc. 1973).. 10
Collins v. *Schoonfield*, 363 F. Supp. 1152 (D. Md. 1973) 10
Donaldson v. *O'Connor*, 234 So. 2d 114 (Fla. 1969), *cert. denied*, 400 U.S. 869 (1970) 9
Donaldson v. *O'Connor*, 390 U.S. 971 (1968) 9
Donaldson v. *Florida*, 371 U.S. 806 (1962) 9
Eslinger v. *Thomas*, 476 F.2d 225 (4th Cir. 1973) 9, 10
Jackson v. *Indiana*, 406 U.S. 715 (1972) 7
People ex rel. Anonymous v. *La Burt*, 14 App. Div. 2d 560, 218 N.Y.S. 2d 738 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962) 7, 8
Pierson v. *Ray*, 386 U.S. 547 (1967) 7, 8, 9
Rouse v. *Cameron*, 373 F.2d 451 (D.C. Cir. 1966) 5, 13
Skinner v. *Spellman*, 480 F.2d 539 (4th Cir. 1973) 10
Stachulak v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973) 13
Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974) .. 13
Westberry v. *Fisher*, 309 F. Supp. 12 (D. Me. 1970) .. 8
Whitree v. *State*, 56 Misc. 2d 693, 290 N.Y.S. 2d 486 (Ct. Cl. 1968) 13
Winters v. *Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) 10

Page

Wyatt v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *on submission of proposed standards*, 334 F. Supp. 1341, *enforced*, 344 F. Supp. 373, *appeal docketed sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Aug. 1, 1972) 5, 9, 12

MISCELLANEOUS:

AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS (rev. ed. 1958) 4

Birnbaum, *The Right to Treatment*, 46 A.B.A.J. (1960) 8, 12

Developments in the Law—Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190 (1974) 10

Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judic., 91st Cong., 1st & 2d Sess. 30, 51 (1969-70) 6

Hollister, *Choice of Antipsychotic Drugs*, 127 AM. J. PSYCHIAT. 186 (1970) 11

JOINT INFORMATION SERVICE, AMERICAN PSYCHIATRIC ASS'N & NAT'L ASS'N FOR MENTAL HEALTH, ELEVEN INDICES (1971) 4

Morse, *Tort Liability of the Psychiatrist*, 18 SYR. L. REV. 691 (1967) 13

NAT'L INST. MENTAL HEALTH, STAFFING OF MENTAL HEALTH FACILITIES, UNITED STATES, 1972 (DHEW Pub. No. ADM 74-28, 1974) 6

NAT'L INST. MENTAL HEALTH, STATISTICAL NOTE 109, STAFFING OF STATE AND COUNTY HOSPITALS, UNITED STATES, 1973 (Aug., 1974) 6

Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM J. PSYCHIAT. 1 (1958) 5

U. S. SURGEON GENERAL'S AD HOC COMM. ON PLANNING FOR MENTAL HEALTH FACILITIES, PLANNING OF FACILITIES FOR MENTAL HEALTH SERVICES (1961) 6

VETERANS ADMINISTRATION, ANTIPSYCHOTIC, ANTIANXIETY & ANTIDEPRESSANT DRUGS (MB-11, Sept. 15, 1966) 11

IN THE

Supreme Court of the United States

OCTOBER TERM, 1973

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner*,

v.

KENNETH DONALDSON, *Respondent*.

Brief of American Psychiatric Association as Amicus Curiae in Support of the Grant of Certiorari

---

INTEREST OF AMICUS CURIAE

The American Psychiatric Association (A.P.A.), founded in 1844, is the nation's largest organization of qualified doctors of medicine who specialize in psychiatry. Almost 20,000 of the nation's approximately 25,000 psychiatrists are members of the Association. The A.P.A. has participated as an *amicus curiae* numerous times in cases throughout the country involving mental health issues.

Amicus believes this case to be of historic importance to the future of mental health care in the nation's public mental institutions. The landmark ruling below that there is a constitutional right to treatment, and the difficult question of how to enforce that right, are of immense concern to members of the A.P.A. and to their patients. A grant of certiorari here is essential in order to clarify presently conflicting interpretations of the rights and duties of mental patients and their psychiatrists.

CONSENT OF THE PARTIES

Amicus is filing this Brief with the consent of both parties, whose letters of consent have been filed with the Clerk.

ARGUMENT

The opinion below decides two questions that are fundamental to the future course of mental health care in this country. First, does the involuntarily committed patient at a state mental institution have a constitutional right to a level of treatment reasonably calculated to improve his or her mental condition? Second, assuming there is such a right, who should be responsible for providing the remedy when an institution has inadequate resources to provide that level of treatment?

The court below answered the first question by holding that there *is* a constitutional right to an adequate level of treatment, and that Respondent Kenneth Donaldson did not receive this minimum level of care. Amicus A.P.A. wholeheartedly supports the Court of Appeals decision on this issue. Indeed, as we will discuss in Part I, below, Amicus believes that the importance of this principle and the conflicts between the

states as to its enforcement require a grant of certiorari here. An affirmance of the decision below on this point could provide invaluable guidance to the lower courts and to responsible state agencies by clarifying the contours of this new right to treatment.

Regarding the second major question—the proper remedy for violation of this new right—Amicus believes the court below committed a serious error. As we will discuss in Part II, below, the Court of Appeals has held that the psychiatrist who chooses to work for a woefully understaffed state mental institution can be held *personally* liable when a patient receives insufficient treatment, even though the institution has such inadequate resources that it would be impossible for its doctors to provide adequate care to all their patients. This ruling conflicts with numerous decisions from other courts holding that state officials are not liable personally for damages when in good faith they have been unable to comply with a newly declared constitutional right. Moreover, holding the doctor rather than the institution liable for damages will almost certainly deter psychiatrists from working at the institutions where they are most needed—those where the current level of treatment is the most inadequate. This Court should grant certiorari so that this ruling does not negate much of the potential for good inherent in the lower court's holding on the right-to-treatment issue.

I. THIS COURT SHOULD GRANT CERTIORARI HERE TO AFFIRM THE CONSTITUTIONAL RIGHT TO TREATMENT.

The present case starkly reveals the overwhelming shame and challenge of this nation's mental health care system. The deplorable conditions shown to exist at Florida State Hospital at Chattahoochee ("Chatta-

hoochee") are all too common in many jurisdictions throughout the country. Legislatures and officials in numerous states routinely deny mental hospitals the resources needed to treat their involuntarily committed residents like patients, rather than like prisoners. This Court should grant certiorari so that all such institutions (and the legislatures that support them) will understand their legal duties and begin providing at least the basic minimum level of care that the Fifth Circuit has recognized is a constitutional requirement.

During Mr. Donaldson's fourteen-year confinement, the ratio of patients per staff psychiatrist ranged from 560-1 all the way up to 1000-1. Petition for Certiorari, at 6. After performing other medical and administrative duties, the average hospital staff psychiatrist is able to devote only 47% of his or her time to direct patient care.[1] Thus, if each doctor spent an equal amount of time with each patient, as little as one or two minutes per week would have been available for psychiatric "treatment" of each patient at Chattahoochee. Meaningful psychiatric care was not, and cannot be, provided under such circumstances.

The American Psychiatric Association has promulgated standards for the minimum level of staffing necessary for a public mental hospital to provide even the lowest level of acceptable care.[2] These are truly *minimum* standards, since they "represent a compromise between what was thought to be adequate and what it was thought had some possibility of being realized."

[1] Joint Information Service, American Psychiatric Ass'n & Nat'l Ass'n for Mental Health, Eleven Indices 14 (1971).

[2] American Psychiatric Association, Standards for Hospitals and Clinics 61 (rev. ed. 1958).

Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 Am. J. Psychiat. 1, 7 (1958). Yet even these minimal standards, which have been accepted as guideposts by the courts, *see Rouse* v. *Cameron*, 373 F.2d 451, 457-58 & n.33 (D.C. Cir. 1966); *see also Wyatt* v. *Stickney*, 344 F. Supp. 373, 383 (M.D. Ala. 1972), *appeal docketed sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Aug. 1, 1972), demonstrate that Chattahoochee needed a vastly larger number of doctors than it actually had in order to provide adequate treatment to its resident population. The A.P.A. standards allow no more than thirty acutely ill patients, or 150 chronically ill patients, per full-time psychiatrist. Thus, while each psychiatrist at Chattahoochee averaged 750 patients, of whom 350 were acutely ill,[3] minimum staffing standards demanded *sixteen* full-time psychiatrists in order to treat those patients.

The necessity for a grant of certiorari here to affirm mental patients' constitutional right to treatment arises from the fact that state mental hospital overcrowding and understaffing are common today far beyond the confines of Chattahoochee or the Fifth Circuit. "In many of our hospitals about the best that can be done is to give a physical examination and make a mental note on each patient once a year, and often there is not even enough staff to do this much." Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 Am. J. Psychiat. 1, 7 (1958). A comprehensive report in the early 1960's suggested that no public mental hospital in the United States met

[3] These figures are roughly the midpoints of the data range during the fourteen-year period for each category. *See* Petition for Certiorari, at 6-7.

minimum staffing requirements. U. S. SURGEON GENERAL'S AD HOC COMM. ON PLANNING FOR MENTAL HEALTH FACILITIES, PLANNING OF FACILITIES FOR MENTAL HEALTH SERVICES 39 (1961). Although there has been considerable improvement in recent years,[4] current studies continue to reveal many large mental hospitals with patient-doctor ratios of 500-1 and even higher.[5]

When institutional resources are so low, hospitals become indistinguishable from prisons. Patient "care" is little more than custody, and the treatment rationale for involuntary commitment becomes a cruel hoax. Like Kenneth Donaldson, there are many thousands of people throughout the country who, although suffering from serious mental illness, have committed no crimes and shown no obvious signs of dangerousness to others, *see* 493 F.2d at 517, but whom society has forced into mental institutions to receive treatment for their own

[4] *See* NAT'L INST. MENTAL HEALTH, STAFFING OF MENTAL HEALTH FACILITIES, UNITED STATES, 1972, at 7-9 (DHEW Pub. No. ADM 74-28, 1974).

[5] While the nationwide average patient-psychiatrist ratio in state mental hospitals is now down to approximately 70-1, *county* mental hospitals still average 500 patients per psychiatrist. *Id.* at 53. The range between the highest and lowest statewide patient-psychiatrist ratio (counting all of each state's public mental hospitals) is a staggering 14,300%, the worst state having 143 times more patients per doctor than the best state. *Compare* NAT'L INST. MENTAL HEALTH, STATISTICAL NOTE 109, STAFFING OF STATE AND COUNTY HOSPITALS, UNITED STATES, 1973, at Table 1 (Aug., 1974) (Alabama), *with id.* at Table 1 (Colorado). Reports of individual mental hospitals with a thousand or more patients per psychiatrist are "well known." *Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judic.*, 91st Cong., 1st & 2d Sess. 30, 51 (1969-70).

good. This "*parens patriae*" rationale rings hollow, indeed, when "treatment" turns into neglect.

The court below was the first federal court of appeals to rule that involuntarily committed mental patients have a constitutional right to treatment. *See* 493 F.2d at 519 & n.9. A few courts have rejected the existence of such a right. *See, e.g., People ex rel. Anonymous* v. *La Burt*, 14 App. Div. 2d 560, 218 N.Y.S. 2d 738 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962). More commonly, however, state officials simply assume that no such right exists when they make their staffing and resource decisions, and mental patients fail to bring any judicial action to challenge those decisions. This Court has already noted how infrequently mental patients litigate the states' powers in this area. *Jackson* v. *Indiana*, 406 U.S. 715, 737 (1972). Thus, because of the condition of the people whose rights are affected, conflicts between different states' policies and constitutional interpretations regarding the right to treatment do not necessarily result in a conflict between circuit court decisions. Nevertheless, the conflict is very real and very crucial to the citizens in many jurisdictions outside the Fifth Circuit who are being confined without constitutionally adequate treatment.

This Court should grant certiorari to resolve those conflicting state practices by affirming that there is a constitutional right to treatment.

II. THE LOWER COURT'S STANDARD FOR PERSONAL LIABILITY CONFLICTS WITH THE PRINCIPLE OF PIERSON v. RAY AND WILL HAMPER ENFORCEMENT OF PATIENTS' RIGHT TO TREATMENT.

After concluding that there is a constitutional right to treatment, the Court of Appeals faced the equally important issue of determining the appropriate remedy

for violation of that right. On this issue Amicus believes the lower court seriously erred. The record shows that at Chattahoochee there were so few doctors that it was impossible for them to provide adequate treatment to all their patients. *See* pp. 4-5, *supra*. Yet, the court held that those doctors who stay at the institution and try to treat the huge number of patients there can be liable *personally* for any damages the patients suffer from lack of treatment. This ruling is fundamentally unfair to the doctors and is contrary to the patients' interest in obtaining more medical treatment.

At least prior to this case, the law was well settled that a state official should not be held personally liable for a civil rights violation when he or she had tried in good faith to follow then-existing constitutional principles, even if those principles later were overturned. As this Court held in *Pierson* v. *Ray*, 386 U.S. 547, 557 (1967), state officers are not "charged with predicting the future course of constitutional law." They "neither can nor should be expected to be seers in the crystal ball of constitutional doctrine." *Westberry* v. *Fisher*, 309 F. Supp. 12, 17 (D. Me. 1970).

In the instant case, a constitutional right to treatment was little more than a gleam in the eye of its most ardent proponent during Mr. Donaldson's confinement, which began in 1957. The article generally credited as the first even to suggest such a right appeared in 1960. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); *see* 493 F.2d at 519-20 & nn.12, 14. Several courts during the 1960's refused to recognize the existence of a constitutional right to treatment. *See, e.g., People ex rel. Anonymous* v. *La Burt*, 14 App. Div. 2d 560, 218 N.Y.S.2d 728 (1961), *appeal*

dismissed and cert. denied, 369 U.S. 428 (1962). Indeed, Mr. Donaldson himself brought several earlier right-to-treatment claims against Dr. O'Connor, and the courts consistently rejected these claims. *See, e.g., Donaldson* v. *O'Connor*, 234 So. 2d 114 (Fla. 1969), *cert. denied*, 400 U.S. 869 (1970). *See also Donaldson* v. *O'Connor*, 390 U.S. 971 (1968); *Donaldson* v. *Florida*, 371 U.S. 806 (1962); *In re Donaldson*, 364 U.S. 808 (1960). It was not until 1971, the year of Mr. Donaldson's release from Chattahoochee, that the first court held that there should be a constitutional right to treatment. *Wyatt* v. *Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971), *appeal docketed sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Aug. 1, 1972).

Under these circumstances it is unfair and contrary to the principle this Court stated in *Pierson* v. *Ray* to apply the right-to-treatment principle retroactively by holding Dr. O'Connor personally liable for damages. Other Circuits have recognized the necessity of "providing conscientious state officials with some protection against the cutting edge of a rapidly developing legal doctrine." *Eslinger* v. *Thomas*, 476 F.2d 225, 229 (4th Cir. 1973). In *Eslinger*, plaintiff challenged the policy of the clerk of the South Carolina State Senate that women were ineligible to serve as senate pages. The Fourth Circuit held that injunctive relief was proper, since the discriminatory policy ran afoul of current constitutional requirements of equal protection. The court went on, however, to reverse the lower court's ruling that the clerk should be liable for damages. The court noted that the defendant's actions had taken place at a time when the law generally tolerated sex-based classifications. *Id.* at 230 & n.5. "Although the clerk may have acted with little sensitivity . . . he

acted in the light of a long-standing, albeit vaguely defined, 'custom' . . . . He did no more, or less, than what had always been done." *Id.* at 229. The Fourth Circuit concluded that the defendant should not be liable for failing to foresee a new constitutional principle. *Id.; accord, e.g., Skinner* v. *Spellman,* 480 F.2d 539 (4th Cir. 1973) (no damages against official acting in "reasonable good faith reliance on what was standard operating procedure"); *Clarke* v. *Cady,* 358 F. Supp. 1156, 1163 (W.D. Wisc. 1973) (prison warden "immune from damages under § 1983 when he reasonably relies upon the validity of a prison practice which has only subsequently been determined to be unconstitutional"); *Collins* v. *Schoonfield,* 363 F. Supp. 1152, 1156 (D. Md. 1973) ("it would contravene basic notions of fundamental fairness if prison officials were held to be liable monetarily for acts which they could not reasonably have known were unlawful").

In the instant case, even if Dr. O'Connor had possessed the prescience to recognize Mr. Donaldson's constitutional right to adequate treatment, Amicus fails to see how Dr. O'Connor could have responded in a way that would have satisfied the court below. Petitioner had as many as *sixteen times* more patients than it was possible to treat properly under accepted professional standards. *See* pp. 4-5, *supra.* Moreover, Mr. Donaldson himself rejected for religious reasons[6] the medication therapy which is generally recognized as one of the most effective forms of treatment for his

[6] *See Winters* v. *Miller,* 446 F.2d 65 (2d Cir.), *cert. denied,* 404 U.S. 985 (1971) (involuntarily committed Christian Scientist has right to refuse medication treatment). *See also Developments in the Law—Civil Commitment of the Mentally Ill,* 87 HARV. L. REV. 1190, 1350 (1974).

condition.[7] Thus, the staff time and resources needed for adequate treatment of Mr. Donaldson simply were not available at Chattahoochee.

It is no answer to say, as did the Court of Appeals, that Dr. O'Connor should be personally liable because he did not devote as much time to Mr. Donaldson as did Dr. Hanenson, another one of Mr. Donaldson's attending physicians. *See* 493 F.2d at 518.[8] When only one or two minutes per week is available to "treat" each patient, see p. 4, *supra,* a doctor must either devote insufficient time to all patients, or give extra time to some at the expense of many others. The record shows that Dr. Hanenson decided to give a disproportionately large amount of his time to Mr. Donaldson—more time than any doctor at Chattahoochee possibly could devote to each of the 560-1000 persons for whom he or she was responsible. Under the Court of Appeals ruling, however, the extra attention a doctor gives to one patient can become the standard which every doctor in that institution must meet for every patient. Inevitably, to comply with such a rule doctors must provide identical amounts of time to each patient, regardless of levels of need. This "lowest common denominator" approach substitutes a mathematical rule for medical judgment. It ignores the harsh reality that even the sharpest knife cannot cut a small pie into enough

[7] *See, e.g.,* Hollister, *Choice of Antipsychotic Drugs,* 127 AM. J. PSYCHIAT. 186, 188 (1970); VETERANS ADMINISTRATION, ANTIPSYCHOTIC, ANTIANXIETY & ANTIDEPRESSANT DRUGS 3 (MB-11, Sept. 15, 1966).

[8] Although the lower court paid lip service to the propriety of allowing doctors a "good faith" defense in cases of this kind, *see* 493 F.2d at 527, it effectively eliminated such a defense by ignoring the evidence that insufficient resources at Chattahoochee made adequate treatment impossible. *See* pp. 4-5, *supra.*

servings to sustain 1000 starving people. The fact is that no matter how each doctor at Chattahoochee chose to divide it, his total time for patient care was just too small to go around.

It is an unspeakable tragedy when a mentally ill person is crowded into a facility like Chattahoochee, given little or no medical treatment, and allowed to remain there for years on end. Amicus believes strongly that such conditions violate the patient's constitutional right to treatment. The responsibility for a remedy, however, must lie with those who have the power to correct these conditions.[9]

The courts can find effective remedies for these problems by focusing on the institutional setting and resources available for treatment. In *Wyatt* v. *Stickney,* 325 F. Supp. 781 (M.D. Ala. 1971), *on submission of proposed standards,* 334 F. Supp. 1341, *enforced,* 344 F. Supp. 373, *appeal docketed sub nom. Wyatt* v. *Aderholt,* No. 72-2634 (5th Cir., Aug. 1, 1972), the court has used its equitable power to require state institutions to increase their staff-patient ratio to the level necessary to provide adequate care. *See* 344 F. Supp. at 387. The American Psychiatric Association is participating in the *Wyatt* case, supporting the right to treatment and urging the court to order a variety of needed institutional reforms. *See* Motion of

[9] Supporters of the right to treatment generally recognize that the understaffing and lack of physical facilities that plague our state mental institutions are not the fault of the psychiatrists or others who work there. "Our society should be grateful to, rather than adversely critical of, the personnel who continue to work in these institutions under the present trying conditions." Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499, 500 (1960); *accord, e.g.,* Birnbaum, *Some Remarks on the Right to Treatment,* 23 ALA. L. REV. 623, 628 (1971).

American Psychiatric Association for Leave to Participate as *Amicus Curiae, Wyatt* v. *Aderholt,* No. 72-2634 (5th Cir., filed Dec. 4, 1972). The other right-to-treatment cases relied upon by the court below similarly focus on institutional reforms and injunctive relief. *See Welsch* v. *Likins,* 373 F. Supp. 487 (D. Minn. 1974); *Stachulak* v. *Coughlin,* 364 F. Supp. 686 (N.D. Ill. 1973). *See also Rouse* v. *Cameron,* 373 F.2d 451, 458-59 (D.C. Cir. 1966) (institution must release patient receiving inadequate treatment). When a state institution fails to meet these minimum standards identified by the courts, a damage action should lie *against the responsible state agency.*[10] *See Whitree* v. *State,* 56 Misc. 2d 693, 290 N.Y.S. 2d 486 (Ct. Cl. 1968) ($300,000 award against state for improper custodial confinement of mental patient). Indeed, such actions may be the most effective method to loosen the legislatures' pursestrings, so that sufficient resources do become available. *See* 82 HARV. L. REV. 1771, 1776-77 (1969).

Instead of such institutional remedies, the Fifth Circuit has held that the doctor who works on the staff of an overcrowded hospital is personally liable for damages to patients he or she is unable to treat. This decision has frightening implications for the very patients whose right to treatment the court was seeking to protect. Unless this Court grants certiorari it would be foolish for qualified doctors to continue working at Chattahoochee or the many other institutions that are similarly understaffed. Rather than stay in a system where their best efforts could not eliminate constant exposure to large damage awards, doctors will seek posi-

[10] The doctor should be personally liable, of course, if he commits any acts of malpractice. *See generally* Morse, *Tort Liability of the Psychiatrist,* 18 SYR. L. REV. 691 (1967).

tions in private practice, or at the better-staffed institutions. Rather than increasing the quality and quantity of treatment available at Chattahoochee, the decision below will lead to just the opposite result.

The Court of Appeals indicated in its opinion that the "core of the charge" against Dr. O'Connor was that he confined Mr. Donaldson "knowing that [he] was not receiving adequate treatment and knowing that absent such treatment the period of his hospitalization would be prolonged." 493 F.2d at 513. The tragic truth is that the grossly inadequate resources in our state mental hospitals today require many of our country's best psychiatrists in painful candor to confess their guilt to this same charge. The question this Court should review is whether our judicial system can help correct the institutional inadequacies that are depriving thousands of mental patients of their fundamental rights, or whether instead the judicial response will be to punish and drive away the people who are doing the most to deal with these problems.

CONCLUSION

For the foregoing reasons, Amicus respectfully urges this Court to grant a writ of certiorari.

Respectfully submitted,

E. Barrett Prettyman, Jr.
Allen R. Snyder
Hogan & Hartson
815 Connecticut Ave.
Washington, D.C. 20006
Attorneys for Amicus Curiae

Supreme Court, U. S.
FILED
OCT 15 1974
MICHAEL RODAK, JR., CLERK

Supreme Court of the United States

October Term, 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner,

v.

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF OF STATE OF OHIO AMICUS CURIAE

WILLIAM J. BROWN
Ohio Attorney General
ANDREW J. RUZICHO
BARBARA J. ROUSE
Ohio Assistant Attorneys General
State Office Tower
Columbus, Ohio 43215
Attorneys for the State of Ohio, Amicus Curiae

THE GATES LEGAL PUBLISHING CO. CLEVELAND, OHIO—TEL. (216) 621-9647

TABLE OF CONTENTS

Interest of State of Ohio	1
Opinion Below	2
Question Presented	2
Statement of Case	3
Summary of Argument	3
Argument	3
Conclusion	6

TABLE OF AUTHORITIES

Cases

Davis, et al. v. Watkins, et al., CA No. 73-205 (N.D. Ohio) 2

Jackson v. Indiana, 406 U.S. 715 (1972) 4

Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972) 5

Millard v. Cameron, 373 F.2d 468 (D.C.Cir 1966) 5

Miller v. Overholser, 206 F.2d 415 (D.C.Cir. 1953) 5

Morales v. Turman, 364 F. Supp. 166 (E.D. Texas 1973) 5

Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974) 5

Robinson v. California, 370 U.S. 660 (1962) 3

Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) 4

Stachulak v. Coughlin, 364 F. Supp. 686 (N.D. Ill. 1973) 5

United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969) *cert. denied*, 396 U.S. 847 (1969) 5

Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974) 5

Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *on submission of proposed standards*, 334 F. Supp. 1341, *enforced*, 344 F. Supp. 373, 387, *appeal docketed sub nom, Wyatt v. Aderholt*, No. 72-2634 (5th Cir. 1972) 1, 4-5

Supreme Court of the United States

October Term, 1974

No.

J. B. O'CONNOR, M.D.,
Petitioner,

v.

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF OF STATE OF OHIO AMICUS CURIAE

INTEREST OF STATE OF OHIO

The State of Ohio has a direct and immediate interest in the recognition of a constitutional right to treatment. Confined in 28 Ohio facilities for the mentally ill and mentally retarded are approximately 18,350 persons, approximately one-half of whom were committed and currently remain hospitalized involuntarily. The State believes that each involuntarily committed patient has "a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971).

Ohio demonstrated its firm commitment to mental health care when it admitted the existence of such a right in its Answer filed in a suit involving persons committed to a state facility for the criminally insane.[1] Any decision concerning the constitutional right to treatment will affect the citizens of Ohio and the state officials responsible for delivering mental health services to the people.

Thus, the State of Ohio, acting by and through the Attorney General of the State, respectfully submits this brief as *amicus curiae* pursuant to Rule 42, of the Revised Rules of the Supreme Court of the United States, requesting a denial of the petition for writ of certiorari on the "right to treatment" issue.[2]

OPINION BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 493 F.2d 507.

QUESTION PRESENTED

Whether a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.

---

[1] *Davis, et al. v. Watkins, et al.*, CA No. 73-205 (N.D. Ohio). This case, a class action filed against state officials alleged, *inter alia*, a constitutional right to treatment for patients involuntarily committed for the purpose of treatment. On September 9, 1974, United States District Judge Nicholas Walinski recognized the constitutional right to treatment and defined the parameters of such a right. The order is comprehensive and will have significant ramifications for the treatment of all persons confined in Ohio mental health facilities; to now have the Supreme Court of the United States grant certiorari in this case and later hold that such a right does not exist would adversely affect the State's action to correct mental health conditions.

[2] We do not address the two additional issues raised by petitioner.

STATEMENT OF CASE

The State of Ohio adopts the summary of the facts of record as found in the unanimous opinion of the court below, 493 F.2d 507 at 510-515.

SUMMARY OF ARGUMENT

To confine a person involuntarily because of a mental disability for the purpose of providing treatment and to fail to provide such treatment is cruel and unusual punishment in contravention of the Eighth Amendment's cruel and unusual proscription and the Fourteenth Amendment's due process and equal protection clauses. The State of Ohio believes that if laws committing persons to state institutions are enacted by state legislatures for benevolent purposes, certain constitutional rights flow from such statutes. Laws confining persons involuntarily for the purpose of treatment can only be justified if treatment is provided. A state legislature's duty to its citizenry does not end upon passage of a statute requiring treatment for patients; a further duty arises to ensure that such treatment is provided. Substantial constitutional issues are raised if the state undertakes the benevolent purpose of providing treatment and subsequently fails to provide it.

ARGUMENT

There are two significant cases decided by this Court which shed substantial light upon the existence of a constitutional right to treatment. In *Robinson v. California*, 370 U.S. 660 (1962), a California statute imposing a ninety-day prison sentence on narcotics addicts was struck down as contrary to the proscriptions of the Eighth Amendment. The Court held that a person would not be punished for an illness, a condition or a "status" from which he

could not voluntarily extricate himself. Finding addiction to be an illness, the Court suggested that a statute making the condition or "status" of mental illness a criminal offense punishable by imprisonment without treatment would meet the same determination of unconstitutionality. This principle applies with equal force to a person afflicted with mental illness, for to recognize the malady and fail to provide the necessary opportunity for treatment when that is the purpose of confinement "violates the very fundamentals of due process." *Wyatt v. Stickney*, 325 F. Supp. 781 at 785 (M.D. Ala. 1971).

In *Jackson v. Indiana*, 406 U.S. 715 (1972), this Court examined the case of a criminal defendant indefinitely committed solely on account of his incompetency to stand trial and found that "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." It is just such a mandate which the State of Ohio is following in recognizing that the *quid pro quo* for "therapeutic" involuntary confinement is treatment.

Other federal courts have evolved standards of care and constitutional safeguards for persons confined in various state institutions and are persuasive in sustaining a right to treatment for involuntarily committed persons. In *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), the Court of Appeals for the District of Columbia upheld a right to treatment on statutory grounds but *in dicta* emphasized that the absence of treatment might raise the specter of possible constitutional violations.

Three district courts have enunciated a right to treatment for civilly committed mentally ill and mentally retarded persons. In *Wyatt v. Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), *on submission of proposed standards*, 334 F. Supp. 1341, *enforced*, 344 F. Supp. 373, 387, *appeal*

docketed sub nom, Wyatt v. Aderholt, No. 72-2634 (5th Cir. 1972), the court set forth minimum constitutional standards for adequate treatment of the mentally ill and the mentally retarded, detailing the requirements for a humane psychological and physical environment. *See Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973), right to treatment for the mentally ill; and *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974), right to treatment for the mentally retarded.

Other institutions have come under similar scrutiny. With respect to training schools for juveniles, courts have applied the theory that commitment without treatment becomes punishment for "status" in violation of the Eighth Amendment. *See Nelson v. Heyne*, 491 F.2d 352 (7th Cir. 1974), a medium security institution for juveniles, approximately one-third of whom were non-criminal offenders; *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972) juveniles classified as "Persons in Need of Supervision" (PINS); *Morales v. Turman*, 364 F. Supp. 166 (E.D. Texas 1973), where the Court found a constitutional right to treatment for juveniles adjudicated delinquent and involuntarily committed. *See also Millard v. Cameron*, 373 F.2d 468 (D.C. Cir. 1966); *Miller v. Overholser*, 206 F.2d 415 (D.C. Cir. 1953); and *United States ex. rel. Schuster v. Herold*, 410 F.2d 1071 (2d Cir. 1969) *cert. denied*, 396 U.S. 847 (1969).

CONCLUSION

Because the weight of judicial authority supports the United States Court of Appeals for the Fifth Circuit's decision on the right to treatment issue, the petition for writ of certiorari should be denied.

WILLIAM J. BROWN
Attorney General

ANDREW J. RUZICHO
BARBARA J. ROUSE
Ohio Assistant Attorneys General

State Office Tower
Columbus, Ohio 43215

Attorneys for the State of Ohio, Amicus Curiae

Supreme Court, U. S.
FILED
OCT 3 1974
MICHAEL RODAK, JR., CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1974

NO. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

REPLY BRIEF FOR PETITIONERS PURSUANT TO RULE 24(4)

ROBERT L. SHEVIN
Attorney General

DANIEL S. DEARING
Chief Trial Counsel

RAYMOND W. GEAREY
Assistant Attorney General

The Capitol
Tallahassee, Florida 32304

TABLE OF AUTHORITIES

Cases

Page

In re Brooks Estate,
32 Ill.2d 361, 205 N.E.2d
435 (1965) 2

Holmes v. Silver Cross Hospital
of Joliet, Illinois,
340 F.Supp. 125 (N.D.Ill. 1972). . 3

Winters v. Miller,
446 F.2d 65 (2nd Cir. 1971),
cert. den. 404 U.S. 985. 2

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

NO. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

REPLY BRIEF FOR PETITIONERS PURSUANT TO RULE 24(4)

In his response to the Petition for Writ of Certiorari, Respondent raises an issue not previously raised. Petitioner submits this Reply Brief pursuant to Rule 24(4), Rules of the Supreme Court, to discuss that issue alone.

In the Petition for Writ of Certiorari, Petitioner argued that the facts demonstrated that Respondent Donaldson, a Christian Scientist, had repeatedly refused various forms of previously beneficial treatment and had, therefore, assuming there exists a constitutional right to treatment, waived his right to treatment. Respondent argues in response that neither he nor any other involuntarly mental patient, committed

following a judicial determination of incompetence should be considered mentally competent to waive such a right.

The trial court instructed the jury that Donaldson's refusals of treatment should be considered. However, when that point was raised on appeal by the co-defendant Gumanis, the Court of Appeals for the Fifth Circuit dismissed the "waiver" argument as "without merit." (493 F.2d at 531.)

Petitioner would argue that assuming there exists a right to treatment, certain mental patients should be considered to be competent to waive that right, regardless of a prior judicial determination of legal incompetency. This argument sounds completely inconsistent, but finds support in recent decisions.

In Winters v. Miller, 446 F.2d 65 (2nd Cir. 1971), cert. den. 404 U.S. 985, the Court of Appeals upheld the claim of a practicing Christian Scientist who was involuntarily admitted to a hospital and given medication over her continued objections. The court noted that the patient had never been judicially declared incompetent, but noted that where the patient's religious views pre-dated by some years any allegations of mental illness or incompetency and where there was no contention that the current mental illness in any way altered those views, there may well be no justification for ignoring the patient's wishes. The court noted the decision in In re Brooks Estate, 32

Ill.2d 361, 205 N.E.2d 435 (1965), wherein the Illinois Supreme Court ruled that where approaching death has weakened the mental faculties of a theretofore competent adult to a point where he may be properly declared incompetent, he may not be compelled by a state appointed conservator to accept treatment of a nature which would probably save his life, but which is forbidden by his religious views and which he has steadfastly refused even though aware that death would result from such refusal.

This theory was carred forward in Holmes v. Silver Cross Hospital of Joliet, Illinois, 340 F.Supp. 125 (N.D.Ill. 1972), wherein an administratrix brought suit under the Civil Rights Act of 1871 alleging that the civil rights of the decedent were violated when an appointed conservator authorized blood transfusions in spite of a prior request to the contrary by the deceased, made before losing consciousness. The court found that although the decedent was incompetent by reason of his state, that he was entitled to have his religious convictions honored in the absence of some substantial state interest. The court went on to suggest that a balancing test should be applied which would consider the status of any dependants and other factual information not before the court.

Petitioner submits that Respondent's theory that no person adjudged to be incompetent can knowingly and intelligently waive the asserted right to treatment must fail. Such a position forces treatment

on those who would not have it and in so doing tramples the constitutional rights of members of the very class sought to be protected.

The District Court placed the question of the effect of Respondent's refusals of treatment in the hands of the jury and the Court of Appeals rejected completely the theory of an incompetent asserting such rights. Petitioner would argue that the question of waiver is a crucial adjunct of the right to treatment argument and that neither the District Court or the Court of Appeals gave adequate consideration to this issue and its effect on the question of Petitioner's liability.

Conclusion

For these reasons, and those already presented in our Petition for Writ of Certiorari, we respectfully submit that this Court should grant certiorari in this case.

Respectfully submitted,

ROBERT L. SHEVIN
Attorney General

DANIEL S. DEARING
Chief Trial Counsel

RAYMOND W. GEAREY
Assistant Attorney General

Dept. of Legal Affairs
The Capitol
Tallahassee, Florida

Counsel for Petitioner.

Certificate of Service

I HEREBY CERTIFY that a copy of the foregoing Reply Brief for Petitioners Pursuant to Rule 24(4) was furnished, by mail, to EUGENE Z. DUBOSE, ESQ., New Hampshire Legal Assistance, 3 Water Street, Washua, New Hampshire 03060; BRUCE J. ENNIS, ESQ., New York Civil Liberties Union, 84 Fifth Avenue, New York, New York 10011; MORTON BIRNBAUM, ESQ., 225 Tompkins Avenue, Brooklyn, New York 11216; GEORGE DEAN, ESQ., Post Office Box 248, Destin, Florida 32541; KENT SPRIGGS, ESQ., 118 North Gadsden Street, Tallahassee, Florida 32301; and JAMES G. MAHORNER, ESQ., Department of Health and Rehabilitative Services, 1323 Winewood Boulevard, Tallahassee, Florida 32301, this 2ND day of October, 1974.

Daniel S. Dearing

Daniel S. Dearing

Supreme Court, U. S.
FILED
DEC 5 1974
CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

No. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE PETITIONER

ROBERT L. SHEVIN
Attorney General

DANIEL S. DEARING
Special Assistant Attorney General

RAYMOND W. GEAREY
Assistant Attorney General

The Capitol
Tallahassee, Florida 32304

December 5, 1974

SUBJECT INDEX

	Page
Opinion Below	1
Jurisdiction	2
Questions Presented	2
Constitutional Provisions Involved	2
Statutory Provisions Involved	3
Statement of the Case	4
Summary of Argument	15
Argument	17
Conclusion	58

CITATIONS

Cases: Page

Anonymous, People ex rel v. LaBurt, 369 U.S. 428 (1962)..... 12

Anonymous, People ex rel v. LaBurt, 385 U.S. 936 (1966)..... 12

Beverly's Case, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603)..... 20

Brooks Estate, In re, 32 Ill.2d 361, 205 N.E.2d 435 (1965) 47

Burnham v. Department of Public Health, 349 F.Supp. 1335 (N.D.Ga. 1972), *reversed and remanded*, --F.2d--, (5th Cir. 11/8/74).....29, 38

Clarke v. Cady, 358 F.Supp. 1156, (W.D.Wis. 1973)..... 54

Collins v. Hardyman, 341 U.S. 651 (1951)..... 43

Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973).... 54

Covington v. Harris, 419 F.2d 617 (D.C.Cir. 1969)..... 28

Curry, In re, 452 F.2d 1360 (D.C.Cir. 1971).... 28

Dobson v. Cameron, 383 F.2d 519 (D.C.Cir. 1967)..... 28

Donaldson, In re,
364 U.S. 808 (1960)..... 12

Donaldson v. Florida,
371 U.S. 806 (1963)..... 12

Donaldson v. O'Connor,
390, U.S. 971 (1968)..... 12

Donaldson v. O'Connor,
400 U.S. 869 (1970)..... 12

Eslinger v. Thomas,
476 F.2d 225 (4th Cir. 1973)..... 54

Fleming v. Adams, 377 F.2d 975,
977 (10th Cir. 1967); *cert. den.*
389 U.S. 898 (1967)..... 43

Fullington v. Shea, 320 F.Supp.
500 (D.Colo. 1970); *affirmed*
404 U.S. 963 (1970)..... 42

Greenwood v. United States,
350 U.S. 366 (1956)..... 34

Hammer v. Rosen, 7 App.Div. 2d
216, 181 N.Y. S. 2d 805 (1959).... 37

Holmes v. Silver Cross Hospital of
Joliet, Illinois, 340 F.Supp. 125
(N.D.Ill. 1972)..... 48

Humphrey v. Cady,
405 U.S. 504 (1972)..... 17

Isenberg v. Prasse,
433 F.2d 449 (3rd Cir. 1970)..... 38

Jacobson v. Massachusetts,
197 U.S. 11 (1905)..... 41

Lake v. Cameron, 124 U.S.App.D.C.
264, 364 F.2d 657, 663 (1966).... 31

Mayfield v. Craven, 433 F.2d 873
(9th Cir. 1970)..... 40

McGowan v. Maryland,
366 U.S. 420 (1961)..... 42

McKinney v. DeBord,
324 F.Supp. 928 (E.D.Cal. 1970).. 54

Mackey v. Procunier, 477 F.2d 877
(9th Cir. 1973)..... 51

Millard v. Cameron, 373
F.2d 468 (D.C.Cir. 1966)..... 28

Mutual Life Ins. Co. v. Terr,
15 Wall. 580, 21 L.Ed. 236 (1873) 24

Niklaus v. Simmons,
196 F.Supp. 691 (D.Neb. 1961).... 43

Oakes, In re Josiah,
8 L.Rep. 123 (1845-46)..... 22

Ogden v. Saunders,
12 Wheat. 213, 281-82 (1827)..... 49

Pierson v. Ray,
386 U.S. 547, 555-557
(1967)..... 54

*Penn Dairies v. Milk Control
Commission*, 318 U.S. 261 (1943).. 41

Prince v. Massachusetts,
321 U.S. 158 (1944)..... 41

Rouse v. Cameron, 373 F.2d 451,
457 N. 30 (D.C.Cir. 1966)..... 27, 28
35, 37, 43, 49

Runnels v. Rosendale, 499
F.2d 733 (9th Cir. 1974)..... 51

Skinner v. Spellman,
480 F.2d 539 (4th Cir. 1973)..... 54

Smith v. Clapp, 436 F.2d 590,
(3rd Cir. 1970)..... 38

*Southern Pacific R.R. Co. v.
United States*, 189 U.S. 447,
450 (1903)..... 55

Stachulak v. Coughlin,
364 F.Supp. 686 (N.D.Ill. 1973).. 29

Stanley v. Georgia,
394 U.S. 557 (1968)..... 51

*Stephens, United States ex rel v.
LaBurt*, 373 U.S. 928 (1963)..... 12

Stone v. Egeler, 377 F.Supp.
115 (W.D.Mich. 1973)..... 54

Taylor v. Perini,
365 F.Supp. 557 (N.D.Ohio 1972).. 54

Tribby v. Cameron,
379 F.2d 104 (D.C.Cir. 1967)..... 28

United States v. Klein,
325 F.2d 283, 286 (2nd Cir. 1963) 33

Virginia Coupon Cases,
114 U.S. 270, 303 (1885)..... 45

Welsch v. Likins,
373 F.Supp. 483 (D.Minn. 1974).... 28

Westberry v. Fisher,
309 F.Supp. 12 (D.Me. 1970)..... 54

Winters v. Miller, 446 F.2d 65
(2nd Cir. 1971), *cert. den.*
404 U.S. 985..... 47

Wyatt v. Aderholt,
--F.2d-- (11/8/74)..... 29,
38, 42, 44

Wyatt v. Stickney, 325 F.Supp. 781
(M.D.Ala. 1971), on submission
of proposed standards, 334 F.Supp.
1341, enforced, 344 F.Supp. 373,
387..... 32, 49, 53

United States Constitution:

Amendment XIV, §1.....2, 3

Federal Statutes.

42 U.S.C. §1983..... 3

28 U.S.C. §1343(3)..... 4

State Statutes and Codes:

§47.30.130, Alaska Statutes, (1969 Supp.)..... 46

§7104, California Wel. & Inst. Code, (1969 Supp.)..... 46

§7104, California Wel. & Inst. Code. 46

D.C. Code Ann. §21-562 (1967)..... 28

Law Reviews, Books and Articles:

American Psychiatric Association, *Position and Statement on the Question of Adequacy of Treatment*, 123 Am.J.Psychiatry 1458, 1459, 1460..... ... 35, 50

Bazelon, *Implementing the Right to Treatment*, 36 U.Chi.L.Rev. 742 (1969)..... 34

Birnbaum, *A Rationale for the Right*, 57 Geo.L.J. 752 (1969)..... 55

Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960)..... ....25, 53, 55, 56

Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623, 635-636 (1971)..... 11, 55, 56

Holmes, *Uncollected Letters*, 66..... 49

1 W. Blackstone, *Commentaries*, 303-07 (9th ed. 1783)..... 20

Cameron, *Nonmedical Judgment of Medical Matters*, 57 Geo.L.J. 716 (1969).....30, 36

Cardozo, *The Paradoxes of Legal Science* (1928)..... 54

6 Coke's Third Inst. (4th Ed. 1797); 4 Blackstone's *Commentaries* (Lewis ed. 1897)..... 20

Daniel 4:33..... 19

Editorial, *A New Right*, 46 A.B.A.J. 516 (1960)..... 25, 55

J. Frank, *Persuasion and Healing -- A Comparative Study of Psychotherapy* (1961)..... 36

H. Goffman, Asylums -- *Essays on the Social Situations of Mental Patients and Other Inmates* 384 (1961)..... 41

Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 Geo.L.J. 782, 786-787, n. 19 (1969).....36, 46

J. Katz, J. Goldstein, & J. Dershowitz, *Psychoanalysis, Psychiatry and Law*, 728-751 (1967)..... 37

Katz, *The Right to Treatment -- An Enchanting Legal Fiction*, 36 U. of Chi. L. R. 755 (1969).....30, 48, 50

M. Levine, *Psychotherapy in Medical Practice*, 17-19 (1942)..... 30

Luke 8:27-29..... 20

Mark 5:2-5..... 20

A. Miles, *An Introduction to Public Welfare* 79 (1949)..... 22

Miller, Dawson, Dix and Parnas, *Cases and Materials on Criminal Justice Administration and Related Processes -- The Mental Health Process*, 1663 (1971)..... 45

Note: *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv.L.Rev. 1288 (1966)..... 23

Note: *Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right*, 32 Md.L.Rev. 42 (1972)..... 30

Note: *The Nascent Right to Treatment*, 53 Va.L.Rev. 1134 (1967).....23, 46

Pollack, *The History of English Law*, (2nd ed. 1911)..... 20

Reisner, *Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends*.... 38

Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 Mich.L. Rev. 945 (1959)..... 23

Smoot, *Laws of Insanity*, §149 (1929) 42

Szasz, *The Right to Health*, 57 Geo.L.J. 734, 741, 743..... 31

Szasz, *The Right to Psychiatric Treatment: Rhetoric and Reality*, 57 Geo.L.J. 740 (1969)..... 30

I. Winthrop's Journal, p. 144, Reprinted in the *History of New England 1630-1649*, by the Massachusetts Historical Society..... 21

G. Zolborg, *A History of Medical Psychology* (1941)..... 24

1-4, *Current Psychiatric Therapies*, (J. Masserman ed. 1961-64)..... 30

5 *Records of the Governor and Company of Massachusetts Bay in New England* 80 (1854)..... 21

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

No. 74-8

J. B. O'CONNOR, M. D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE PETITIONER

Opinion Below

The Opinion of the Court of Appeals is reported at 493 F.2d 507. No opinion was rendered by the District Court for the Northern District of Florida.

Jurisdiction

The opinion and judgment of the Court of Appeals for the Fifth Circuit were entered on April 26, 1974, and copies thereof were appended to the Petition for Writ of Certiorari. The Petition was filed July 25, 1974, and was granted on October 21, 1974. The jurisdiction of this Court rests on 28 U.S.C. §1254(1).

Questions Presented

(1) Whether there is a constitutional right to treatment for persons involuntarily committed to a state mental hospital.

(2) Whether, assuming there is a constitutional right to treatment, the patient in this case waived that right.

(3) Whether, assuming there is a constitutional right to treatment, staff members at a state mental hospital are liable for monetary damages in a suit under the civil rights act.

Constitutional Provisions Involved

Constitution of the United States of America, Amendment XIV, §1:

> All persons born or naturalized in the United States, and subject to the jurisdiction thereof, are citizens of the United States and of the State wherein they reside. No State shall make or enforce any law which shall abridge the privileges or immunities of citizens of the United States, nor shall any State deprive any person of life, liberty, or property, without due process of law; nor deny any person within its jurisdiction the equal protection of the laws.

Statutory Provisions Involved

42 U.S.C. §1983:

> Every person, who, under color of any statute, ordinance, regulation, custom, or usage, of any State or Territory, subjects, or causes to be subjected, any citizen of the United States or other person within the jurisdiction thereof to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

28 U.S.C. §1343(3):

> To redress the deprivation, under color of any State law, statute, ordinance, regulation, custom or usage, of any right, privilege or immunity secured by the Constitution of the United States or by any Act of Congress providing for equal rights of citizens or of all persons within the jurisdiction of the United States.

Statement of the Case

Kenneth Donaldson, the Respondent, was involuntarily committed to the Florida State Hospital, Chattahoochee, Florida, on January 3, 1957, by a county court judge of Pinellas County, Florida, pursuant to Chapter 394, Florida Statutes, which provided for release upon application by himself, guardian, spouse, parent or next of kin. Such release was conditioned upon there being no objection from the head of the hospital. (§394.21, A. 242). Alternatively, release could be effected by a restoration to mental competency by certificate of three members of the medical staff attested by the superintendent. (§394.22, A. 242). These procedures assumed that the patient had recovered his reason or would pose no danger to himself or others.

The commitment order stated his incompetency was due to paranoid schizophrenia with auditory and visual hallucinations and delusions. The order further stated that Donaldson, then age 50, a resident of four years, required restraint to prevent self-injury or violence to others. Two physicians served as the investigating committee for the proceedings. (A. 187).

Prior to the Florida commitment, Donaldson had been a patient at Marcy State Hospital in New York from March 12, 1943, to June 26, 1943. At that time, his problems were described as auditory hallucinations, ideas of reference, and delusions of persecution. The medical description was Dementia Praecox, Paranoid Type, presently called Schizophrenic Reaction, Paranoid Type.

In January, 1957, at the time of his admission to Florida State Hospital, Donaldson was examined by a Dr. Clark Adair. The examination revealed that Donaldson expressed delusions of persecution for which he blamed "rich Republicans" and believed that the "Foreign Policy Association" had attempted to poison him by placing chemicals in his food. The diagnosis was Schizophrenia, Paranoid Type. (A. 187-193).

At the time of his admission, Donaldson, a Christian Scientist, requested that no medicine or shock therapy be administered and he consistently refused

repeated offers of such forms of therapy during his commitment. In addition, he frequently refused offers of other non-medical forms of therapy as well. (A. 25, 38, 52-7, 75, 95, 114-5, 122-6, 145, 152).

At the time Donaldson was admitted to the hospital in 1957, the Petitioner, Dr. O'Connor, was Assistant Clinical Director. He was in charge of the ward where Donaldson was assigned upon admission. In that position, Dr. O'Connor was Donaldson's attending physician. Dr. Gumanis, a co-defendant below, was a staff physician. (A. 103-105, 154).

On July 1, 1959, Dr. O'Connor became Clinical Director of the hospital, and later that year, Dr. Gumanis succeeded him as Donaldson's attending physician. Dr. O'Connor was subsequently promoted to Superintendent of the hospital on July 30, 1963, and served in that capacity until he retired February 1, 1971. Dr. Gumanis served as Donaldson's attending physician until April 18, 1967. At that time, Dr. Israel Hanenson became Donaldson's attending physician until Dr. Hanenson's death in the fall of 1970. From that time until his release on July 31, 1971, Donaldson was treated by Dr. Jesus Rodriquez. (A. 103-105, 154).

In 1959, Florida State Hospital at Chattahoochee provided services for 1,736,540 patient days per year. In 1970, Florida State Hospital provided services for 1,351,000 patient days per year,

compared to 21,790 patients days in the psychiatric section of one of Florida's largest, non-government hospitals, Tampa General Hospital, for the fiscal year 1967-68.

During Mr. Donaldson's assignment to Department A of Florida State Hospital, there were two doctors available; making a doctor patient ratio, at times, of 560/1000 patients for each doctor. In 1960, two doctors were responsible for 1000 patients. Previously, only one doctor had this responsibility. During Donaldson's stay in Department C of the hospital, there was one physician and one psychiatrist for approximately 800 patients.

In 1970, Florida State Hospital provided services for 1,351,000 patient days per year with a staff of 17 psychiatrists, seven physicians, and four psychologists, a total of 28 legislatively approved treating-type positions. Only 50% of each doctor's time was available for psychiatry. The remainder had to be devoted to medical matters and administration.

The American Psychological Association describes the optimum doctor-patient ratio to be one psychiatrist for each 50 acutely ill patients and one psychiatrist for each 125 chronically ill patients. There were approximately 200-500 acutely ill patients alone at Florida State Hospital during the time in question here.

Throughout the time Dr. O'Connor was Donaldson's attending physician, Donaldson continued to refuse to receive medication and shock treatment due to religious views. It should be noted that a prior exposure to such treatment in New York had been somewhat successful. This refusal continued when Dr. Gumanis assumed responsibility in 1959. During the approximately six and one-half years Donaldson was in Dr. Gumanis' care, written notes indicate he had consultation with staff doctors at least 51 times. Testimony at trial indicated that many other consultations probably occurred, but were not recorded.

Psychological examinations conducted in 1960 and 1961 showed no significant change from previous findings of incompetency. During June, 1963, Helping Hands, a Minneapolis group, requested information about Donaldson and sought his release. Dr. Gumanis and Dr. O'Connor denied the suggested release because Donaldson continued to require strict supervision. Psychological tests administered in 1964 continued to show no significant changes in Donaldson's condition. An earlier test, scheduled late in 1963, had been refused by Donaldson. (A. 230-241)

During January, 1964, a meeting of nine members of the staff recommended continued hospitalization. The written opinion of the staff, issued following

the meeting with Donaldson, found him dangerous to others and recommended further hospitalization. Donaldson complained to a member of the state legislature who subsequently arranged an interview and examination by an independent psychiatrist, Dr. Franklin J. Calhoun. Dr. Calhoun concluded:

> That the results of my examination were in complete accord with the diagnostic evaluation of the hospital staff. This man has the type of mental illness that is most difficult for lay persons to detect. Even a psychologist or psychiatrist could be 'fooled' by Mr. Donaldson unless certain types of psychological tests are included in the evaluation. Unless his condition has greatly improved since my examination, I still feel very strongly that Mr. Donaldson is ill, dangerous to society, and should remain hospitalized. (A. 222, 195-196).

During the summer of 1964, a Mr. John Lembcke, a certified public accountant, in Binghamton, New York, and a former classmate of Donaldson's at Syracuse University in the 1920's, began seeking Donaldson's release. Mr. Lembcke made four attempts between 1964 and 1968 to obtain Donaldson's release. All requests for release were denied due to the opinion of the staff that Donaldson was

dangerous to himself and others, and required strict supervision and treatment which they believed Mr. Lembcke would be unable to provide. (A. 82-97).

During 1966, Donaldson again refused a psychological examination and continued to refuse traditional forms of medication and shock therapy, but did participate in mileau therapy, religious therapy and recreational therapy. (A. 115).

On April 18, 1967, Donaldson was placed under the care of Dr. Hanenson who ordered another set of psychological tests. The examination, conducted July 13, 1967, showed no significant improvement in Donaldson's condition. Dr. Hanenson ordered another test sequence on March 13, 1968, at which time Donaldson showed the first signs of improvement since 1957. Possible trial visits were suggested. On March 21, 1968, Dr. Hanenson presented Donaldson to a staff meeting. The staff found improvement in his condition and suggested trial visits. Although Donaldson was approved for trial visits, Dr. O'Connor rejected Mr. Lembcke's suggestions of a complete release.

On September 9, 1968, Donaldson was given to a work assignment and granted grounds privileges. Testing conducted during November, 1969, indicated release at an early date. A report was submitted to Dr. O'Connor on February 6, 1970, and another, summarizing all psychological

testing was submitted on March 27, 1970. Another physician, Dr. F. D. Walls, examined Donaldson and reported unfavorably on March 27, 1970. During the fall of 1970, at the death of Dr. Hanenson, Dr. Jesus Rodriquez assumed the position of Donaldson's attending physician. He evaluated Donaldson and noted that he had again refused to work,had refused group therapy and refused other suggested forms of therapy. (A. 152, 204).

On March 4, 1971, Donaldson was again assigned to a general routine work assignment. On July 1, 1971, Dr. Milton J. Hirshberg assumed the post of Superintendent of Florida State Hospital. He examined Donaldson on July 26, 1971, and declared him to be a schizophrenic, paranoid type, in remission and recommended his release. Kenneth Donaldson was released from Florida State Hospital on July 31, 1971.

Prior to the present case, Kenneth Donaldson had brought fifteen separate petitions for a writ of habeas corpus in the state courts of Florida and lower federal courts.[1] All petitions were unsuccessful and on four occasions Donaldson petitioned this Court for a writ of certiorari.

The series began in 1960 when the

---

[1] Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623, 635-636 (1971).

Florida Supreme Court denied a writ of habeas corpus refusing to openly state whether there is, or is not, a constitutional right to treatment. This Court denied certiorari. *In re Donaldson*, 364 U.S. 808 (1960). Similar denials of a writ of habeas corpus were also brought before this Court in 1963 and 1968. *Donaldson v. Florida*, 371 U.S. 806 (1963); *Donaldson v. O'Connor*, 390 U.S. 971 (1968).

In 1970, Donaldson, represented by counsel, again sought review of his case. Certiorari was again denied. *Donaldson v. O'Connor*, 400 U.S. 869 (1970). During this same period, at least three other cases in which various courts had refused to rule on the issue of whether there exists a constitutional right to treatment were brought before this Court. In each case, certiorari was denied. *People ex rel Anonymous v. LaBurt*, 385 U.S. 936 (1966); *United States ex rel Stephens v. LaBurt*, 373 U.S. 928 (1963); *People ex rel Anonymous v. LaBurt*, 369 U.S. 428 (1962).

This suit was initiated in the District Court for the Northern District of Florida prior to Donaldson's release on July 31, 1971. The initial complaint was styled a class action on behalf of all patients in Department C of the Hospital. In addition to damages, for Donaldson and the class, the complaint sought habeas corpus relief as to Donaldson and the class, and injunctive relief requiring the hospital to provide adequate treatment. After Donaldson's release, the

District Court dismissed the case as to the class action allegations, and the first amended complaint was filed on August 30, 1971. The amended complaint sought individual damages and renewed Donaldson's prayers for declaratory and injunctive relief to restrain the enforcement of Florida's civil commitment statutes unless Florida provided adequate treatment to its civilly committed mental patients. Jurisdiction was alleged pursuant to 42 U.S.C. §1983, 28 U.S.C. §1343(3), and 28 U.S.C. §§ 2281, 2284. The amended complaint also asked the district court to convene a three-judge court to consider the plaintiff's attack on the constitutionality of the civil commitment statutes as they then operated. On November 30, however, the plaintiff in a memorandum brief, abandoned the prayer that a three-judge court be convened. The prayers for injunctive and declaratory relief were eliminated from the case.

The key allegation in the amended complaint charged that the defendants O'Connor and Walls had "acted in bad faith toward Plaintiff and with intentional, malicious, and reckless disregard of his constitutional rights." The complaint alleged examples of such actions, including the denial to Donaldson of grounds privileges; the refusal of the psychiatrists to speak with him, even at his own request; refusal or obstruction of his opportunities for out-of-state discharge, despite a recommendation by a staff conference

that he be given such a discharge, and despite the presentation of a signed parental consent to such a discharge. The core of the charge, however, was that Walls and O'Connor acted intentionally and maliciously in "confining Donaldson against his will, knowing that [he] was not physically dangerous to himself or others"; in confining him "knowing that [he] was not receiving adequate treatment, and knowing that absent such treatment the period of his hospitalization would be prolonged"; and that they "intentionally limit[ed] [his] 'treatment' program to 'custodial care' for the greater part of his hospitalization." Corresponding to these allegations, the complaint sought $100,000 damages against Walls and O'Connor.

The trial began November 21, 1972, and continued for four days. The jury returned a verdict awarding Donaldson $17,000 in compensatory damages and $5,000 in punitive damages against O'Connor, and $11,500 in compensatory damages and $5,000 in punitive damages against Gumanis. The jury returned verdicts in favor of the other three defendants. From the judgment entered on that verdict, Gumanis and O'Connor separately appealed to the United States Court of Appeals for the Fifth Circuit. The Judgment of the District Court was affirmed on April 26, 1974. (493 F.2d 507). Appellant Gumanis filed a timely Motion for Rehearing which had not been ruled on by the Court as of the time of this Brief was filed. Appellant O'Connor filed a timely Petition

for Writ of Certiorari in this Court on July 25, 1974, which was granted October 21, 1974.

Summary of Argument

I.

The essential question to be decided here is whether there exists a constitutional right to treatment for involuntarily civilly committed mental patients. The Court of Appeals ruled that such a right does exist as the *quid pro quo* of confinement. Petitioner argues that the alleged right to treatment is incapable of definition, implementation or enforcement due, in large part, to the uncertain nature of psychiatry.

II.

The second phase of the argument is concerned with the problem of whether, assuming the existence of a right to treatment, some involuntarily committed mental patients should be considered competent to waive that right. Further this portion is concerned with whether Donaldson, by word and deed, effectively waived his right to treatment. Petitioner submits that Donaldson's many refusals of treatment constituted an effective waiver of the right and that he should not have been heard to complain of a denial of treatment.

III.

The final portion of the argument is concerned with the retroactive application of the alleged right to treatment which occurred in this case. Prior to 1971, the year of Donaldson's release, there had been no judicial pronouncements of a right to treatment. Indeed, the first time a Court of Appeals had so ruled was in this case. Petitioner submits that it was unjust to establish the right and then proceed to enforce it in retrospect in a case involving individual monetary liability of a state employee. Petitioner further argues that he was acting in good faith pursuant to what he believed was proper procedure and should not be held liable for failure to predict the emergence of a new and controversial constitutional right.

ARGUMENT

I.

THERE IS NO CONSTITUTIONAL RIGHT TO TREATMENT FOR PERSONS INVOLUNTARILY CIVILLY COMMITTED TO A STATE MENTAL HOSPITAL.

A. The basis of the decision below.

The Court of Appeals held that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition. [2] The Court of Appeals found that civil commitment entails a "massive curtailment of liberty" in the constitutional sense, citing *Humphrey v. Cady*, 405 U.S. 504 (1972), and noted that the due process clause of the Fourteenth Amendment to the United States Constitution guarantees a right to treatment upon a two-part theory.

The first part of the theory is concerned with the rationale for confinement. In its discussion, the Court of Appeals noted that three distinct

---

[2] 493 F.2d 507, 520.

grounds are recognized by state statutes: danger to self; danger to others; and need for treatment, or for "care," "custody," or "supervision." The Court placed these grounds into two categories; one a "police power" rationale for confinement, the other a "*parens patriae*" rationale. Danger to others was considered a "police power" rationale; need for care or treatment a "*parens patriae*" rationale; and danger to self as an area combining elements of both. The Court reasoned that where, as in Donaldson's case, the basis for confinement evokes the *parens patriae* rationale, that the patient is in need of treatment, the due process clause requires that the deprivation of liberty brought on by commitment be accompanied by treatment. It was this theory the Court applied in this case notwithstanding an express finding in Donaldson's original commitment papers that he required "...restraint to prevent him from self-injury or violence to others..." and considerable evidence that numerous physicians felt Donaldson was dangerous to others, which would bring elements of the police power rationale into consideration.

The second part of the theory is concerned with the traditional limitations on a government's right to confine -- that confinement be in retribution for a specific offense; that it be limited to a fixed term; and that it follow a proceeding where

fundamental due process safeguards are present. Ignoring the due process protections inherent in the initial commitment hearing, the Court of Appeals found that where such limitations are absent, such as in an involuntary civil commitment to a state mental hospital, there must be a *quid pro quo* extended by the government to justify confinement. The Court then noted that the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment. [3]

B. Historical treatment of the mentally ill.

A discussion of whether there exists a constitutional right to treatment requires a brief examination of the historical basis for involuntary hospitalization of the mentally ill.

Insanity and the necessary care of the insane has been one of society's problems from the earliest of times. There are Biblical references to the primitive practice of driving the unfortunates out into the wilds to care for themselves, die from want, fall prey to wild animals, or revert to a condition little above the animals themselves, as in the case of the Babylonian king, Nebuchadnezzar. [4] As

---

[3] 493 F.2d 522.

[4] Daniel 4:33

late as the time of Christ, the insane were found living in caves and abandoned tombs and were often a problem to the neighborhood. [5]

Some enlightenment had occurred by the time of Blackstone and Lord Coke. Coke noted, and Blackstone endorsed the view, that the execution of a madman "should be a miserable spectacle, both against law, and of extreme inhumanity and cruelty, and can be no example to others." [6]

Later, in 1603, Lord Coke described the law of insanity as it had developed in England and discussed the Statute de Praerogation Regis, which explicated the King's authority over the property of the mentally ill and outlined the King's duty to care for them in *Beverly's Case*, 4 Co.Rep. 123(b), 76 Eng.Rep. 1118 (K.D. 1603). Later, during the Eighteenth century, confinement was a privilege reserved for the more affluent. According to Blackstone, one applied for confinement only when the disorder was regarded as permanent and the individual could afford the cost of such confinement. [7]

---

[5] Mark 5:2-5; Luke 8:27-29.

[6] 6 Coke's Third Inst. (4th ed. 1797); 4 Blackstone's Commentaries (Lewis ed. 1897).

[7] 1 W. Blackstone, *Commentaries*, 303-07 (9th ed. 1783); 2 F. Pollack & F. Maitland, *The History of English Law* (2nd ed. 1911).

During the Colonial period in the United States, families were expected to care for the mentally ill. In the absence of family the Colonial community would not provide care, but would attempt to send the individual back to where he or she came from. In Governor Winthrop's Journal, it is reported that on December 11, 1634, "[o]ne Abigail Gifford, sent by ship into this country, and being found to be somewhat distracted, and a very burdensome woman, the governor returned her to England by warrant to the same parrish, in the ship Rebecca." [8] Some years later, the Massachusetts Bay Company enacted legislation for the detention of violent persons so "that they do not damnify others," [9] the rationale being that if the individual was a threat to the community, the community could act accordingly.

The emergence of the idea of danger within the purview of organized medicine appears to have been accomplished in 1769 when the first institution for the insane was opened at Williamsburg,

---

[8] I Winthrop's Journal, p. 144, Reprinted in the *History of New England 1630-1649*, by the Massachusetts Historical Society.

[9] 5 *Records of the Governor and Company of the Massachusetts Bay in New England* 80 (1854).

Virginia. The chartering act made specific reference to the need for restraining those "who may be dangerous to society." [10] The community's role in providing for the violent and insane who could not be maintained properly by their families was clearly established at that early time. The emphasis remained on detention, rather than treatment.

Detention was apparently rarely challenged in the early days of our nation. One of the first cases was brought in 1845 when Josiah Oakes petitioned the Massachusetts Supreme Court by writ of habeas corpus to determine the legality of his confinement. *In re Josiah Oakes*, 8 L.Rep. 123 (1845-46). Although the attending physician could not predict with any degree of certainty that Oakes would indeed engage in a dangerous act were he not confined, the Court relied on the *possibility* of danger as a decisive factor against him. The Court ruled that restraint was permissible because "the right to restrain an insane person of his liberty is found in that great law of humanity, which makes it necessary to confine those who goings at large would be dangerous to themselves and others." The Court further states:

---

10 A. Miles, *An Introduction to Public Welfare* 79 (1949).

> The necessity which creates the law, creates the limitations of the law. The question must then arise in each particular case, whether a patient's own safety or that of others requires that he should be maintained for a certain time, and whether restraint is necessary for his restoration or will be conducive thereto. The restraint can continue as long as the necessity continues. That is the limitation and the proper limitation.

The basis of a state's right to confine mentally ill persons against their will rests upon the dual reasons of (1) the power of the state in its role of *parens patriae*, and (2) its duty to protect under the police power. [11] A state has an obvious interest in the safety of all citizens and the maintenance of a healthy and productive citizenry. It might be argued that the *parens patriae* theory alone cannot justify confinement without benefit to or treatment of the individual, [12] but it

---

11 Ross, *Commitment of the Mentally Ill: Problems of Law and Policy*, 57 Mich.L.Rev. 945 (1959).
Note: *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv.L. Rev. 1288 (1966).

12 Note:*The Nascent Right to Treatment*, 53 Va.L.Rev. 1134 (1967).

cannot be reasonably or responsibly argued that society does not have the right under the police power theory to confine mentally ill persons with a propensity for dangerous behavior, with or without accompanying treatment.

The origins of insanity were, by 1873, still much a mystery to physicians, laymen and the courts alike as evidenced by the following quotation which appeared in *Mutual Life Ins. Co. v. Terry*, 15 Wall. 580, 21 L.Ed. 236 (1873):

> The causes of insanity are as varied as the varying circumstances of man.
>
> '...some for love, some for jealousy, for grim religion some, and some for pride, Have lost their reason; some for fear of want, Want all their lives; and others every day, For fear of dying, suffer worse than death.'

Treatment, as a goal of confinement of mentally ill persons, emerged with the development of psychiatry as a medical specialty and the successful development of drug and shock therapy during the first half of this century. At this point, the states began to provide such care as was possible within the limitations of state resources. [13]

---

[13] G. Zolborg, *A History of Medical Psychology*, (1941).

C. The emergence of the right to treatment theory.

The idea that there exists a constitutional right to treatment for the involuntarily committed mental patient was first set forth in 1960 in an editorial in the American Bar Association Journal. [14] The editorial has as its impetus an article of Dr. Morton Birnbaum, of the New York Bar, appearing in the same issue. [15]

In his initial article, Dr. Birnbaum suggested the need for recognition of a right to treatment and based his suggestion on the realization that care in state mental hospitals is often substandard. Dr. Birnbaum recognized that inadequate treatment does not often result from individual action by the medical staff, but from inadequate legislative funding:

> As the law has not recognized this right, the state can, and generally does, compel the public mental institution to give adequate medical treatment to its inmates. The state does this: (A) by compelling the institutionalization

---

[14] Editorial, *A New Right*, 46 A.B.A.J. 516 (1960).

[15] Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

> of those persons whom it considers to be sufficiently mentally ill to require institutionalization for care and treatment; and, (B) by not appropriating sufficient funds to enable the public mental institution to obtain the number of competent personnel and to maintain the adequate physical plant that is necessary to provide therapeutic, rather than custodial, care for these sick people.
>
> * * *
>
> In too many cases, the efficacy of modern medicine is dependent upon a legislative decision rather than upon medical knowledge. If the legislature appropriates sufficient funds to enable the public mental institution to provide proper medical care, the effect of institutionalization is decided to a great extent by the limitations of medical knowledge. If the legislature appropriates insufficient funds, the effect of institutionalization is decided to a great extent by legislative fiat.

The article further suggests that assuming recognition of a right to treatment, that the proper form of remedy would be release, pursuant to

habeas corpus proceedings, for those receiving inadequate care. It was thought that the prospect of wide-scale release of mentally ill persons would force the states to either provide adequate care or abandon public mental health institutions altogether. Dr. Birnbaum noted the obvious threat to the health and welfare of the general citizenry and patients, but felt that such action was justified by the eventual improvement of public institutions.

At the conclusion of his article, Dr. Birnbaum noted several problems with the recognition and enforcement of a right to treatment. The most important of these was the practical realization that in order to avoid the problem of wide-scale release of mentally ill persons and other injustices, that the courts should provide a reasonable interim period between recognition of the right and enforcement of the right.

There was no judicial recognition of a constitutional right to treatment for several years following Dr. Birnbaum's suggestion of such a right. In 1966, the Court of Appeals for the District of Columbia held in *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), that a patient committed involuntarily to a mental hospital under a District of Columbia Statute had a statutory right to treatment pursuant to the District of Columbia 1964 Hospitalization of

the Mentally Ill Act. [16] In addition, Judge Bazelon, writing for the majority, stated that, even absent such a statute, forced confinement in a public mental hospital without treatment might violate either the due process clause, the equal protection clause, or the Eighth Amendment. Since 1966, the District of Columbia Circuit has reaffirmed its holding in Rouse v. Cameron, *supra*, on several occasions. [17]

Several other district courts have also considered the question of whether there is a constitutional right to treatment capable of definition and deliniation. The resulting decisions and remedies have not been uniform. The Court in *Rouse* felt that *habeas corpus* relief would be the proper remedy for a present patient not receiving adequate rehabilitative treatment and examined the treatment on a subjective, individual patient basis. Subsequent cases such as *Welsch v. Likens*, 373 F.Supp. 483 (D.Minn. 1974),

---

16 D. C. Code Ann. §21-562 (1967).

17 *In re Curry*, 452 F.2d 1360 (D.C. Cir. 1971); *Covington v. Harris*, 419 F.2d 617 (D.C.Cir. 1969); *Tribby v. Cameron*, 379 F.2d 104 (D.C.Cir. 1967); *Dobson v. Cameron*, 383 F.2d 519 (D.C. Cir. 1967); *Millard v. Cameron*, 373 F.2d 468 (D.C.Cir. 1966).

and *Stachulak v. Coughlin*, 364 F.Supp. 686 (N.D.Ill. 1973) also focus on institutional reform rather than individual treatment. Another district court rejected the proposed right to treatment as completely unworkable in *Burnham v. Department of Public Health*, 349 F.Supp. 1335 (N.D.Ga. 1972). This decision was recently reversed and remanded based upon the decisions of the Court of Appeals for the Fifth Circuit in *Wyatt v. Aderholt*, --F.2d--, (11/8/74), and the present case. The present case represents the first instance in which a former patient has sought and received damages from individual state psychiatrists upon a theory that they confined him knowing he was not receiving adequate treatment and that absent such treatment the period of his confinement would be prolonged. This radical departure from institutional remedies raises frightening implications for staff and patients alike. Competent staff will be driven away from inadequate institutions, leaving the patients with little hope of a cure, dumped into the often unwilling or unprepared hands of their families.

D. The difficulties of defining and enforcing a consitutional right to treatment for mental patients.

However attractive the theory of a right to psychiatric treatment may be to all persons concerned with the

preservation of individual liberties, serious problems arise from the attempted application and enforcement of such a right. These problems are of both a legal and medical nature and have been the subject of considerable commentary. [18]

The overriding problem in defining and applying a right to treatment lies in the problem of judges and juries untrained in medicine and the highly specialized field of psychiatry attempting to second guess the judgment of trained physicians and psychologists concerning what constitutes "adequate treatment."

As early as 1942, over forty (40) distinct methods of psychotherapy were accepted by the medical profession. [19]

---

[18] Szasz, *The Right to Psychiatric Treatment: Rhetoric and Reality*, 57 Geo.L.J. 740 (1969); Cameron, *Non-Medical Judgment of Medical Matters*, 57 Geo.L.J. 716 (1969); Note, *Guaranteeing Treatment for the Committed Mental Patient: The Troubled Enforcement of an Elusive Right*, 32 Md.L.Rev. 42 (1972); Katz, *The Right to Treatment--An Enchanting Legal Fiction*, 36 U. of Chi. L.R. 755 (1969).

[19] M. Levine, *Psychotherapy in Medical Practice*, 17-19 (1942). 1-4, *Current Psychiatric Therapies* (J. Masserman ed. 1961-64).

These methods listed by a text range from active physical treatment such as "shock therapy" to more subtle forms of therapy such as ignoring certain symptoms and attitudes. Dr. Thomas S. Szasz observes the difficulties involved in presently defining what constitutes "illness," "treatment," and "patient" are severe enough without the confusing injection of an indefinable right to treatment. [20] As Dr. Szasz points out that it is extremely difficult to determine not only whether certain behavior constitutes "illness" but to determine what constitutes the best method of treatment or whether the chosen treatment is "adequate."

Dr. Szasz believes that what is termed a "right" to treatment should be labelled a "claim" for treatment and points out that a "right" to treatment for the patients would seriously impair a physician's prerogatives of choosing his patients and methods of treatment. This conflict is heightened in a state mental hospital where a physician cannot choose his patients.

The impossibilities of judicial definition and application of a right to treatment were discussed by now Chief Justice Burger in *Lake v. Cameron*, 124 U.S.App.D.C. 264, 364 F.2d 657, 663 (1966):

---

[20] Szasz, *The Right to Health*, 57 Geo. L.J. 734, 741, 743.

> ...this Court now orders the District Court to perform functions normally reserved to social agencies by commanding search for a judicially approved course of treatment or custodial care for this mentally ill person who is plainly unable to care for herself. Neither this Court nor the District Court is equipped to carry out the broad geriatric inquiry proposed or to resolve the social and economic issues involved.

It has been strenuously argued in this and preceding cases that expert testimony is sufficient to guide a judge or jury to a proper determination as to what constitutes proper and adequate treatment in any specific case. The Court of Appeals accepted and applied that theory in this case. While the testimony of experts and guidelines formulated by professional associations may be helpful in determining the adequacy of care provided by an entire hospital or system such as in an inquiry as in Wyatt v. Stickney, *supra*, it cannot be easily applied to an individual patient. To attempt such application is to subject the professional judgment and decisions of a trained physician to the scrutiny of untrained laymen. It is common knowledge that any two physicians rarely treat any individual in the identical manner. One physician may consider some form of active treatment essential while another may choose to treat the symptoms by ignoring them.

A graphic illustration of a court faced with two widely divergent expert views on proper treatment, raised in the context of incompetence to stand trial, is provided in *United States v. Klein*, 325 F.2d 283, 286 (2nd Cir. 1963), wherein the Court lamented:

> Mental disorders being what they are, it is not surprising that eminent psychiatrists differ as to methods of treatment. Here Dr. Shoefield believed Klein would respond to a more psychoanalytic form of therapy; Dr. Douglas, by his own testimony, favored a more physiological approach. Courts of law, unschooled in the intricacies of what may be the most perplexing of medical sciences, are ill-equipped to choose among such divergent but responsible views. In a case like this, where a man's life may literally hang in the balance, a judge ought not undertake the hazardous venture of changing the course of psychiatric treatment without, at the least, a much fuller hearing and a greater preponderance of expert testimony than existed here.

Advocates of the right to treatment tend to ignore the difficulties of laymen sitting in judgment of the decisions of trained physicians with the argument that any judge who can allocate AM radio frequencies to avoid electronic interference is capable of

determining, with the aid of experts, which manner of treatment is "adequate" or "proper." [21]

This argument ignores the difference between the more exact science of electronics and the vague, fluid theories of psychotherapy. While it may be possible to determine whether one radio station will interfere with another with some degree of certainty, it has been demonstrated above that it cannot be said with equal certainty that one method of treatment is superior to another in any particular case.

This Court recognized the dilemma in *Greenwood v. United States*, 350 U.S. 366 (1956), wherein Justice Frankfurter noted the transiency of psychiatry when reviewing the testimony of two psychiatrists, declaring:

> ...their testimony illustrates the uncertainty of diagnosis in this field and the tentativeness of professional judgment. The only certain thing that can be said about the present state of knowledge and therapy regarding mental disease is that science has not reached finality of judgment....

An examination of portions of Donaldson's hospital records in the Appendix will reveal

---

21 Bazelon, *Implementing the Right to Treatment*, 36 U.Chi.L.Rev. 742 (1969).

similar differences of opinion between the staff physicians.

Following the decision in *Rouse v. Cameron*, the American Psychiatric Association released a policy statement on the adequacy of treatment. [22]

The A.P.A. statement contends that "[t]he definition of treatment and the appraisal of its adequacy are matters for medical determination," but sets forth seven considerations relevant to a determination of whether a patient is receiving adequate care: (1) The purpose of hospitalization, and differences between long-term and short-term treatment programs; (2) the degree to which treatment is changed as diagnosis develops during institutionalization; (3) the need to protect the patient from self-inflicted harm; (4) the importance of interrupting the disease process, as in separating the psychotic from his family stress situation; (5) the effective use of physical therapies; (6) efforts to change the emotional climate around the patient meaning "mileau therapy" and related measures; and (7) the availability of conventional psychological therapies. [23] The statement strongly

---

22 American Psychiatric Association, *A Position Statement in the Question of Treatment*, 123 Am.J. Psychiatry, 1458 (1967).

23 *Id.* at 1458-1459

stresses the importance of considering the limitations of the staff and facilities at hand, and the absolute need for cooperation by the patient in his treatment program.[24]

The difficulties encountered by attempted judicial assessment of psychiatric treatment opinions and techniques reach the point of the ridiculous when, as in the present case, a court judicially declares a form of treatment long accepted by psychiatrists to be an "amorphous and intangible concept" frequently asserted by defendant psychiatrists as a concealment or smoke screen tactic. The Court emphasized its displeasure with "mileau therapy" citing a law review article, written by an attorney, as support for the notion that "mileau therapy" is an excuse used by psychiatrists to cover up a lack of adequate treatment.[25] Articles by physicians and psychiatrists take the opposite view that "mileau therapy" is often an excellent alternative or companion to medical or shock therapy.[26]

---

24 *Id.* at 1459-1460.

25 Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 Geo.L.J. 782, 786-787, n. 19 (1969).

26 Cameron, *Nonmedical Judgment of Medical Matters*, 57 Geo.L.J. 716, 731 (1969); J. Frank, *Persuasion and Healing--A Comparative Study of Psychotherapy* (1961).

It has been suggested that it is no more difficult for a judge or jury to determine whether a patient has received "adequate" treatment than to hear a traditional medical malpractice case.[27] However, the analogy is not accurate. Physical medicine has a relative certainty compared with psychotherapy, both in diagnosis and in the efficacy of particular treatments. In the psychiatric malpractice field, the courts have exhibited extreme reluctance to examine issues of treatment and great confusion in trying to decide when negligence has occurred. Most of the cases involve such matters as discharge or failure to prevent escape from an institution, not the superiority of one form of treatment or therapy over another.[28] When a patient sues the doctor or hospital for negligent treatment, as in shock therapy injury cases, there is no comparison of treatments, but rather an examination of how the particular treatment was administered.[29]

---

27 *Rouse v. Cameron*, 373 F.2d at 457, n. 30.

28 J. Katz, J. Goldstein, & J. Dershowitz, *Psychoanalysis, Psychiatry, and Law*, 728-751 (1967).

29 CF. *Hammer v. Rosen*, 7 App.Div. 2d 216, 181 N.Y. S. 2d 805 (1959).

Negligence, a traditional guiding point for courts and juries in medical malpractice litigation, will be missing from federal cases seeking to enforce a constitutional right to treatment because negligence cannot form the basis of jurisdiction under the Civil Rights Acts. *Smith v. Clapp*, 436 F.2d 590 (3rd Cir. 1970); *Isenberg v. Prasse*, 433 F.2d 449 (3rd Cir. 1970).

The difficulties of one District Judge in attempting to define and apply a right to treatment are described in *Burnham v. Department of Public Health*, 349 F.Supp. 1335 (N.D.Ga. 1972), *reversed and remanded*, --F.2d-- (5th Cir. 11/8/74), wherein Chief District Judge Smith explored the requirements of civil rights jurisdiction, the nature of the asserted right to treatment, and the impossibilities of its definition and responsible application. Judge Smith concluded that there exists no affirmative federal constitutional right to treatment. His decision was recently reversed and remanded by the Court of Appeals for the Fifth Circuit on the authority of their decision in this case and Wyatt v. Aderholt, *supra*.

Subsequent commentary highly recommends the approach taken by the District Court in *Burnham*.[30] Professor Reisner notes that while objective standards might be judicially developed to be applied to

---

30 Reisner, *Psychiatric Hospitalization and the Constitution: Some Observation on Emerging Trends*.

institutions as a whole, he concludes that judicial attempts to gauge the appropriateness of treatment offered to individual patients cannot help but encounter the difficulties foreseen by the *Burnham* court.[31]

The Court of Appeals for the Fifth Circuit brushed aside objections that courts are incapable of determining what constitutes "adequate" treatment with the view that since other courts had attempted to do so, it must be that the judiciary is perfectly capable of sitting in judgment of the professional decisions of trained physicians. The Court also noted that there were cases, declaring the case at bar to be one, where the jury could determine whether a patient has been denied his "rights" by comparing the care he received under one physician to that he received under another. Both theories place laymen in the position of psychiatrists and the latter does not, as the Court of Appeals suggests, avoid the determination of which treatment or therapy is "adequate" or "proper" in any particular case.

A jury cannot be expected to accurately evaluate which of dozens of valid, acceptable treatments is best or any particular patient. Indeed, no cause of action should arise under the Civil Rights Act, if the only question is whether the

---

31 *Id.*

most appropriate treatment was applied.[32]

The Court of Appeals argued further that a jury would be justified in finding a denial of "rights" by concluding that the defendants below obstructed the release of a patient even though they knew he was not receiving treatment. This theory ignores the fact that physicians in a state mental hospital are required to accept all patients committed to their care and are not empowered to release a patient until he is "cured." Even though a doctor may realize that a patient is not receiving treatment, or does not benefit from the available treatment, due to lack of available staff, facilities, operating funds or other reasons, a doctor in a state institution simply lacks the statutory authority to release a mentally ill patient.

The Court of Appeals held that a *quid pro quo*, in the form of adequate treatment, must be advanced by the state in exchange for the liberty of the involuntarily committed mental patient. This theory ignores the realities providing the basic justification for involuntary confinement of the mentally ill. Involuntary commitment rests upon two interrelated foundations: (1) the "police power" of the state; and (2) the state's

---

32 *Mayfield v. Craven*, 433 F.2d 873 (9th Cir. 1970).

role as "*parens patriae*." The two are not easily separated in this setting. Basically, when the state provides mental health facilities for its citizens it acts in *parens patriae*. When the state involuntarily commits a citizen to a state mental health institution, it acts pursuant to its traditional police powers to protect the general public. A state has a strong interest in a healthy, productive, educated society.[33] Accordingly, for the benefit and protection of society, the state provides for state custody and maintenance of incompetent persons. The state undertakes to care for those persons whose mental illness makes it difficult or impossible for them to care for themselves or to be cared for by their families, until such time as the patient is considered well enough to return to society. The state promises that and nothing more.

Professor Hugh Goffman has suggested, somewhat critically, that the true clients of state mental health facilities are the relatives of the patient, the police, and the judges.[34] This theory was noted

---

33 *Penn Dairies v. Milk Control Commission*, 318 U.S. 261 (1943); *Prince v. Massachusetts*, 321 U.S. 158 (1944); *Jacobson v. Massachusetts*, 197 U.S. 11 (1905).

34 H. Goffman, Asylums -- *Essays on the Social Situations of Mental Patients and Other Inmates* 384 (1961).

rejected as morally and constitutionally unacceptable by the Court of Appeals for the Fifth Circuit in *Wyatt v. Aderholt*, --F.2d-- (5th Cir. 11/8/74). Consistent with its *quid pro quo* theory, the Court also rejected the theory that custodial care and safekeeping of mental patients is sufficient to justify confinement. This position ignores the fact that the historical basis for the existence of state mental health institutions was to safeguard the individual and society, and relieve the family of the financial and physical burden of caring for the mentally ill.[35]

The nature of treatment supplied beyond custodial care is a question for the states, not the federal courts. Whether a state shall provide a particular governmental service, and if so in what amount (qualitatively and quantitatively) are generally questions for the states and do not raise federal constitutional issues cognizable under 42 U.S.C. §1983, the Civil Rights Act of 1871, and 28 U.S.C. §1343(3).[36] It must be remembered that not every governmental

---

35 Smoot, *Laws of Insanity*, §149 (1929).

36 *Fullington v. Shea*, 320 F.Supp. 500 (D.Colo. 1970), affirmed 404 U.S. 963 (1970); CF. *McGowan v. Maryland*, 366 U.S. 420 (1961).

function implies a corresponding right or "*quid pro quo*" as it has been termed by the Court of Appeals. *Collins v. Hardyman*, 341 U.S. 651 (1951); *Niklaus v. Simmons*, 196 F.Supp. 691 (D.Neb. 1961).

An analogous situation might be that of the public schools. School attendance is compulsory so it might be argued that there must, therefore, be a constitutional right to an adequate education as the *quid pro quo* to those persons forced to attend school. Definition of such a right might be equally incapable of accurate definition. However, the *quid pro quo* theory has not been extended to the public schools. There is no right to an education even though attendance is involuntarily compelled.[37]

It was admitted by Respondent, in the pleadings, that there is no statutory right to treatment in Florida, as in the District of Columbia statute before the court in *Rouse v. Cameron*. Petitioner further believes, that there can be no federal constitutional right to treatment, as demonstrated above. Petitioner has shown that aside from the problem of determining what constitutes mental illness, that there is a bewildering array of accepted methods of therapy and a wide divergence of opinion between respected

---

37 *Fleming v. Admas*, 377 F.2d 975, 977, (10th Cir. 1967), *cert. den.* 389 U.S. 898 (1967).

experts as to which method may be proper in a particular case. A right must be capable of definition. The proposed right of treatment defies definition; its application and enforcement are impossible in the absence of a definition.

If the proposed right is to be enforced on the institutional level, such as in Wyatt v. Aderholt, *supra*, by imposition of certain standards drawn in terms of physical plant specifications and doctor-patient ratios, then there are no guarantees that treatment would be adequate on the individual level because the question of whether the particular forms of therapy applied are proper would still be open to argument. Conversely, if the proposed right is to be enforced on the individual level, as in this case, institution-wide reforms would be few and the process agonizingly slow. In addition, the courts would be forced into the position of picking and choosing among the various forms of therapy and, as in this case, overruling the decisions of trained psychiatrists in favor of some other form of therapy. Either choice of remedies serves to highlight the impossibility of serving the rights of all patients. One path favors the general interest of all at the expense of the individual, while the latter serves the individual interest at the expense of other patients and substitutes judicial wisdom for that of trained psychiatrists.

Given the manifold problems of definition and implementation, there can be no constitutional right to treatment. A right must be capable of enforcement. *Virginia Coupon Cases*, 114 U.S. 270, 303 (1885). The proposed constitutional right to treatment ignores the historical basis of state-provided mental health institutions, the difficulties of defining what constitutes adequate treatment, and the greater difficulties of fashioning a remedy which will provide such treatment to all patients. A constitutional right cannot rest upon such grounds.

II.

ASSUMING THERE IS A CONSTITUTIONAL RIGHT TO TREATMENT, DONALDSON WAIVED THAT RIGHT.

Assuming *arguendo* that there exists a constitutional right to treatment, is there a corresponding right to refuse treatment? Or, may a mental patient, by word or deed, waive his right to treatment? Commentators suggest that a right to refuse treatment may be a necessary adjunct to the proposed right to treatment.[38] Statutes in Alaska and

---

[38] Miller, Dawson, Dix and Parnas, *Cases and Materials on Criminal Justice Administration and Related Processes--The Mental Health Process*, 1663 (1971).

California expressly recognize a right to refuse on religious and other grounds.[39]

A natural question arises as to whether persons committed for reasons related to mental competency should be considered competent to consent to, or refuse offered treatment. California and Alaska statutes grant the patient the right to decide so long as the administrators determine that he is in such a "condition of mind as to render him competent to make the decision."[40] Law review proponents of a right to treatment generally refuse, in their zealous protection of the patient's right to treatment, to recognize the right of a patient to refuse treatment.[41]

---

39 §7104, *California Wel. & Inst. Code*, (1969 Supp.); §47.30.130, *Alaska Statutes*, (1969 Supp.).

40 §7104, *California Wel. & Inst. Code.*

41 Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 Geo.L.J. 782, 801 (1969); Note, *The Nascent Right to Treatment*, 53 Va.L.Rev. 1134, 1140 (1967).

Petitioner would argue that assuming there exists a right to treatment, certain mental patients should be considered to be competent to waive that right, regardless of a prior judicial determination of legal incompetency. This argument sounds completely inconsistent, but finds practical support in recent decisions.

In *Winters v. Miller*, 446 F.2d 65 (2nd Cir. 1971), *cert. den.* 404 U.S. 985, the Court of Appeals upheld the claim of a practicing Christian Scientist who was involuntarily admitted to a hospital and given medication over her continued objections. The court noted that the patient had never been judicially declared imcompetent, but noted that where the patient's religious views pre-dated by some years any allegations of mental illness or incompetency and where there was no contention that the current mental illness in any way altered those views, there may well be no justification for ignoring the patient's wishes. The court noted the decision in *In re Brooks Estate*, 32 Ill.2d 361, 205 N.E.2d 435 (1965), wherein the Illinois Supreme Court ruled that where approaching death has weakened the mental faculties of a theretofore competent adult to a point where he may be properly declared incompetent, he may not be compelled by a state appointed conservator to accept treatment of a nature which would probably save his life, but which is forbidden by his religious views and which he has steadfastly refused even though aware that death would result from such refusal.

This theory was carried forward in *Holmes v. Silver Cross Hospital of Joliet, Illinois*, 340 F.Supp. 125 (N.D.Ill. 1972), wherein an administratix brought suit under the Civil Rights Act of 1871 alleging that the civil rights of the decedent were violated when an appointed conservator authorized blood transfusions in spite of a prior request to the contrary by the deceased, made before losing consciousness. The court found that although the decedent was incompetent by reason of his state, that he was entitled to have his religious convictions honored in the absence of some substantial state interest. The court went on to suggest that a balancing test should be applied which would consider the status of any dependants and other factual information not before the court.

The Fifth Circuit rejected all claims of waiver as "without merit." 493 F.2d at 531. Such a position ignores the individual rights of Donaldson and other such patients. Some suggest that a right to treatment imposes a duty to be treated.[42] Justice Holmes supported that view stating:

> While there are in some cases legal duties without a corresponding right; we never see a legal

---

42 Katz, *The Right to Treatment--An Enchanting Legal Fiction?*, 36 U. of Chi. L.R. 755 (1969).

> right without either a corresponding duty or compulsion stronger than duty.[43]

Whether there is a right to refuse treatment or a duty to be treated, the evidence in this case demonstrates conclusively that either Donaldson exercised his right not to be treated or he utterly failed in his duty to be treated. The record is replete with evidence that he not only continually refused medicine and shock therapy, but that he refused, at times, to participate in occupational and group therapies. (*Supra* at pp. 6, 10, 11) The Court in *Rouse v. Cameron* suggested that patient refusal to cooperate in therapy does not excuse lack of adequate treatment, but rather is a further indictment of the treatment facilities and staff. This attitude was prompted primarily by the requirements of the District of Columbia statute involved. However, the Court in *Wyatt v. Stickney* suggested that the same attitude should apply to the constitutional right to treatment. The *Wyatt* standard ignores the patient who refuses treatment or is unamenable to treatment.[44]

---

43 Holmes, *Uncollected Letters*, 66. See also: *Ogden v. Saunders*, 12 Wheat. 213, 281-82 (1827).

44 325 F.Supp. 781, 784 (M.D.Ala. 1971).

While the courts and commentators do not believe patient cooperation is a key element of adequate treatment, the American Psychiatric Association believes patient cooperation is a necessity.[45] No involuntary patient becomes a true "patient" until he is willing to accept help and trust those who offer it. Some commentators have recognized this problem and have suggested that preventative detention may be the only viable alternative.[46]

Donaldson, having continued to refuse numerous types of treatment, including shock treatment which had apparently been a fairly successful element of his New York treatment, should not have been heard to complain of the "inadequacy" of his treatment. Therefore, even assuming the existence of a right to treatment, Donaldson could not present a valid claim. He failed to uphold his corresponding duty to be treated. His actions should have been construed as an effective waiver or repudiation of any right to treatment.

Any claim that all involuntary mental patients, committed following a judicial determination of incompetency, should also

---

45 American Psychiatric Association, *Position and Statement on the Question of Adequacy of Treatment*, 123 Am.J.Psychiatry 1458 (1967).

46 Katz, *The Right to Treatment--An Enchanting Legal Fiction*, 36 U.Chi.L.Rev. 755, 762-763 (1969).

be considered incompetent to waive various forms of therapy or treatment is untenable and unconscionable. Such a position forces treatment upon those who would not have it, whether on religious or other grounds, and in so doing tramples the constitutional rights of members of the very class sought to be protected.[47]

The District Court placed the question of the effect of Respondent's refusals of treatment in the hands of the jury and the Court of Appeals rejected completely the theory of an incompetent asserting such rights. Petitioner would argue that the question of waiver is a crucial adjunct of the right to treatment argument and that neither the District Court or the Court of Appeals gave adequate consideration to this issue and its effect on the question of Petitioner's liability.

Considering the substantial evidence of either a waiver of treatment or, at least, a failure to cooperate with treatment, it is clear that Donaldson lacked a cause of action. The Motion for Directed Verdict made by counsel for Petitioner O'Connor at the close of the Plaintiff's case should have been granted.

---

47 See, e.g., *Runnels v. Rosendale*, 499 F.2d 733 (9th Cir. 1974), citing *Roe v. Wade*, 410 U.S. 113 (1973); see also: *Mackey v. Procunier*, 477 F.2d 877 (9th Cir. 1973), citing *Eisenstadt v. Baird*, 405 U.S. 438 (1972); *Stanley v. Georgia*, 394 U.S. 557 (1968); and Roe v. Wade, *supra*.

III.

ASSUMING THE EXISTENCE OF A RIGHT TO TREATMENT, STATE EMPLOYED PSYCHIATRISTS SHOULD NOT BE HELD PERSONALLY LIABLE FOR A DEPRIVATION OF ADEQUATE TREATMENT.

The Court of Appeals held that it was not improper for the district court jury to have held Petitioner and Dr. Gumanis, the other Appellant below, personally liable for the alleged deprivation of adequate treatment although such deprivation was caused primarily by inadequate staffing and facilities.

Petitioner submits that a psychiatrist in a state mental hospital should not be held personally liable for the deprivation of a constitutional right, whose emergence and enforcement could not have been reasonably foreseen. Furthermore, psychiatrists in a state hospital should not be held liable for deprivation of a constitutional right to adequate treatment, when they have no control over the number or nature of the patients they must treat, the facilities and resources available to them, or the statutory right to either refuse to treat a particular patient or release a patient before he is restored to his mental health. The Court of Appeals found such considerations without merit.

Kenneth Donaldson was committed to Florida State Hospital in 1957 and released

in 1971. The first suggestion of a constitutional right to treatment arose in 1960,[48] a year after Dr. O'Connor left his position as Donaldson's attending physician to become Clinical Director and subsequently Hospital Superintendent. It was not until 1971, the year of Donaldson's release, that the first court held that there was a constitutional right to treatment. *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D.Ala. 1971). The *Wyatt* case dealt not with individual care, however, but with institutional standards, staffing and facilities. No Court of Appeals made a similar pronouncement until the decision below in this case. 493 F.2d 507 at 519.

The basic premise of Donaldson's case was, according to the Brief in Opposition to Petition for a Writ of Certiorari, that Dr. O'Connor deprived "Donaldson of his liberty...even though he knew Donaldson was receiving only...custodial care...." Such a case must be built upon the foundation of an existing right to treatment, yet there was no such right recognized until the year of Donaldson's release.

Dr. O'Connor acted according to what he believed to be the proper course, medically and legally. Custodial care of the mentally ill had been the accepted standard in this country until the last few years when the right to treatment theories began to circulate. Dr. O'Connor's

---

48 Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).

good faith reliance upon then-existing standards should be defense to this action. As noted in the writings of Justice Cardozo, such reliance should not be taken lightly:

> What has once been settled by a precedent will not be unsettled overnight, for certainty and uniformity are gains not lightly to be sacrificed. Above all is this true when honest men have shaped their conduct on the faith of the pronouncement.[49]

Similar sentiments were voiced in *Pierson v. Ray*, 386 U.S. 547, 557 (1967), wherein this Court held that state officers are not "charged with predicting the future course of constitutional law." State officers and employees must be required to act as reasonable and responsible men, but "they neither can nor should be expected to be seers in the crystal ball of constitutional doctrine.[50]

---

49 Cardozo, *The Paradoxes of Legal Science* (1928).

50 *Pierson v. Ray*, 386 U.S. 547, 557 (1967); *Westberry v. Fisher*, 309 F.Supp. 12 (D.Me. 1970). See also: *Stone v. Egeler*, 377 F.Supp. 115 (W.D.Mich. 1973); *Eslinger v. Thomas*, 476 F.2d 225 (4th Cir. 1973); *Taylor v. Perini*, 365 F.Supp. 557 (N.D.Ohio 1972); *Skinner v. Spellman*, 480 F.2d 539 (4th Cir. 1973); *Collins v. Schoonfield*, 363 F.Supp. 1152 (D.Md. 1973); *McKinney v. Debord*, 324 F.Supp. 928 (E.D. Cal. 1970); *Clarke v. Cady*, 358 F.Supp. 1156 (W.D.Wis. 1973).

The controversy in this case centers around the effort to establish a right to treatment and demonstrate that Kenneth Donaldson was denied that right. The inequity arises when the right, if established, is applied retroactively to create monetary liability on the part of Petitioner and Dr. Gumanis. In essence, their wrongful acts, if any, consisted of the violation of a prospective right; assuming the present existence of a right to treatment. Justice Holmes once defined a prospective right as follows:

> A prospective right is not yet a right. It is only an expectation having certain intensity of reasonableness.[51]

It has been known for many years that state mental hospitals are woefully inadequate in terms of physical facilities, staff, and financing.[52] State mental hospitals are a creature and occasional victim of legislative fiat. They exist and operate on the funds made available

---

51 *Southern Pacific R. R. Co. v. United States*, 189 U.S. 447, 450 (1903).

52 Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623 (1971); Birnbaum, *A Rationale for the Right*, 57 Geo. L.J. 752 (1969); Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Editorial, *A New Right*, 46 A.B.A.J. 516 (1960).

by the legislature, and have only as many staff members as allowed by the annual appropriations bill. The administrator and staff have no meaningful control over the facilities and resources at their disposal. Likewise, they must accept every patient sent to them under a valid commitment order. They are not statutorily empowered to refuse any patient committed for care or discharge any patient who has not regained his mental health.

The personal liability that resulted in this case goes far beyond the original theory and conflicts with the statements of its creator and most ardent supporter, Dr. Birnbaum, who is of counsel in this case, and has long maintained that the understaffing and lack of physical facilities that plague state mental institutions and which lead to inadequate treatment, are not the fault of the individual psychiatrists or others who work under such conditions. [53]

Against just such a set of facts, the Court of Appeals found that a doctor in a state institution using the limited resources available to him, could be held personally liable for failing to give adequate treatment, as judged by a court of law.

---

53 Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499, 500 (1960); accord, e.g. Birnbaum, *Some Remarks on the Right to Treatment*, 23 Ala.L.Rev. 623, 628 (1971).

If the situation were not as serious as it is, it would be ludicrous to imagine a federal court finding that an over-worked, under-paid, staff psychiatrist in an over-crowded state hospital, working with a patient-staff ratio averaging five hundred patients per physician, using the meager facilities available to him, could be held personally liable in the amount of $23,000, to a former patient, for failing to foresee the existence of a previously unestablished constitutional right and failing to provide each and every patient with "adequate treatment", pursuant to that right, as determined by a group of laymen.

Respondent attempts to refute Petitioner's claim that he was not statutorily authorized to release Donaldson even though he knew that Donaldson was receiving inadequate treatment which would make recovery slower by pointing to evidence that Donaldson could have been released on temporary home visits and furloughs (A. 100-102). However, such temporary options are not the same as permanent release and are only other forms of treatment. Respondent further points to O'Connor's refusals to release Donaldson to his friend Lembcke (A.210, 221, 229) and the Helping Hands half-way house (A.208), as additional evidence of malice upon which the judgment could stand. Such reliance is misplaced. O'Connor was not empowered to make such a release where the patient was not recovered. Copies of staff conference reports in the Appendix show that refusals of release were not the work of Dr. O'Connor and Dr. Gumanis alone. (A. 194-198, 207-208, 214-229).

Petitioner submits that he should be immune from damages in a situation where he was acting in good faith, according to accepted institutional policy and procedures, and could not reasonably be expected to foresee the future emergence and enforcement of a constitutional right to treatment. State employees should not be exposed to personal monetary liability for acts subsequently condemned as unconstitutional by the recognition of a new constitutional right.

The District Court erred in not directing a verdict in favor of Petitioner after having heard the evidence. The question of liability of Petitioner should not have reached the jury. The evidence reflects that Dr. O'Connor acted properly within the statutory and constitutional framework as it existed then. He should not be penalized in retrospect for actions taken in good faith within the scope of his authority as a hospital superintendent or for judgments made as a physician. Such retroactive application of an emerging constitutional doctrine works great injustice. The judgment of the Court of Appeals should be reversed.

Conclusion

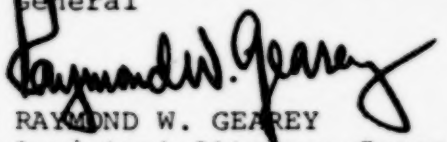
For reasons and under authority set forth above, this Court is respectfully requested to reverse the judgment of the Court of Appeals for the Fifth Circuit.

Respectfully submitted,

ROBERT L. SHEVIN
ATTORNEY GENERAL



DANIEL S. DEARING
Special Assistant Attorney General



RAYMOND W. GEAREY
Assistant Attorney General

Department of Legal Affairs
The Capitol
Tallahassee, Florida 32304

Attorneys for Petitioner.

Supreme Court, U. S.
FILED
JAN 6 1975
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner
v.
KENNETH DONALDSON,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR THE RESPONDENT

BRUCE J. ENNIS, JR.
84 Fifth Avenue
New York, N.Y. 10011

EUGENE DUBOSE, JR.
357 East Chicago Avenue
Chicago, Illinois 60611

BENJAMIN W. HEINEMAN, JR.
PAUL R. FRIEDMAN
MENTAL HEALTH LAW PROJECT
1751 N Street, N.W.
Washington, D.C. 20036
Attorneys for Respondent

Of Counsel:
GEORGE DEAN
Box 248
Destin, Florida 37541

MORTON BIRNBAUM
225 Tompkins Avenue
Brooklyn, N.Y. 11216

January 4, 1975

WILSON - EPES PRINTING CO., INC. - RE 7-6002 - WASHINGTON, D. C. 20001

TABLE OF CONTENTS

	Page
TABLE OF AUTHORITIES	v
OPINION BELOW	1
QUESTIONS PRESENTED	1
STATEMENT OF THE CASE	2
A. Introduction	2
B. Facts	2
1. Respondent was committed to Florida State Hospital in January, 1957, for the purpose of treatment.	3
2. Petitioner knew that respondent received no treatment, and that respondent received only custodial care.	5
3. Despite the inadequate staffing and resources at Florida State Hospital, there were standard modes of treatment that were available, but were not provided for respondent.	10
4. Petitioner knew respondent was not dangerous to himself or to others.	14
5. If released, respondent would have been able to provide for his basic needs in the community: he did not need custodial care.	19
6. Petitioner knew he had the authority, as attending physician and later as superintendent, to release respondent.	22
7. Petitioner did not take the steps he could and should have taken to release respondent, and instead, intentionally blocked respondent's attempts to be released to the supervision of responsible friends and organizations.	24
SUMMARY OF ARGUMENT	31
ARGUMENT	33

TABLE OF CONTENTS—Continued

Page

I. UNDER THE DUE PROCESS CLAUSE, RESPONDENT, WHO WAS INVOLUNTARILY CONFINED AS MENTALLY ILL UNDER NON-CRIMINAL STANDARDS AND PROCEDURES FOR FIFTEEN YEARS AND WHO WAS DANGEROUS NEITHER TO HIMSELF NOR TO OTHERS, HAD A RIGHT TO BE RESTORED TO LIBERTY EITHER BY TREATMENT OR ELSE BY RELEASE 33

A. Respondent's Involuntary Civil Commitment Abridged His Constitutionally Protected Liberty 41

B. The Stated Purpose of Respondent's Involuntary Confinement Was To Provide Him With Treatment for His Mental Illness in Order To Return Him to the Community 44

1. As petitioner knew, the stated purpose of respondent's confinement was to provide treatment so that respondent would be returned to the community. 45

2. Custodial care of a mentally ill person who is neither dangerous to himself nor to others is not a constitutionally permissible purpose for involuntary confinement. 47

3. This Court should not hold that provision of treatment justifies involuntary confinement of a harmless mental patient. 54

C. Due Process Required That the Nature of Respondent's Involuntary Confinement Had To Be Reasonably Related to the Purpose of That Confinement: Respondent Thus Had a Constitutional Right to Treatment Or to Release 56

TABLE OF CONTENTS—Continued

Page

D. Definition of the Right to Treatment: The Trial Court Properly Instructed the Jury That Respondent Should Have Received Such Treatment As Would Have Given Him a Reasonable Opportunity To Be Cured or To Improve His Mental Condition 60

1. The instructions defining the right to treatment were correct. 61

2. The evidence showed, and the jury could have found, that respondent did not receive treatment which would have provided a reasonable opportunity to cure or improve his mental condition. 63

3. Standards defining the right to treatment can be developed in other cases by using the traditional tools of the judicial process. 64

II. IN THE CIRCUMSTANCES OF THIS CASE, THE AWARD OF COMPENSATORY AND PUNITIVE DAMAGES SHOULD BE AFFIRMED 74

A. No Legal Issue Regarding Damages Is Before This Court Because Petitioner Did Not Object to the Relevant Jury Instructions, Either at Trial or on Appeal 75

1. The good faith and reasonableness defense. 75

2. The "retroactivity" claim. 76

B. The Jury Instructions Relevant to the Award of Damages Were in Accord With Applicable Law 77

1. The good faith and reasonableness defense. 77

2. The "retroactivity" claim. 79

TABLE OF CONTENTS—Continued

	Page
C. The Award of Compensatory and Punitive Damages Is Supported by the Evidence	82
D. Affirmance of the Award of Damages Will Not Disrupt Florida's Mental Health System	84
E. Petitioner's "Waiver" Argument Is Not Properly Before This Court, and Is Without Merit	85
CONCLUSION	88

TABLE OF AUTHORITIES

Cases:	Page
Adickes v. *S. H. Kress and Co.*, 398 U.S. 144 (1970)	76, 79
Anderson v. *Nosser*, 456 F.2d 835 (5th Cir. 1972)	80
Arnett v. *Kennedy*, 94 S.Ct. 1633 (1974)	41
Atlantic & Gulf Stevedores, Inc. v. *Ellerman Lines, Ltd.*, 369 U.S. 355 (1962), *rehearing denied*, 369 U.S. 882 (1962)	50
Baker v. *Carr*, 369 U.S. 186 (1962)	61
In re Ballay, 482 F.2d 648 (D.C. Cir. 1973)	36, 43, 58
Baxstrom v. *Herold*, 383 U.S. 107 (1966)	31, 43
Bivens v. *Six Unknown Named Agents*, 456 F.2d 1339 (2d Cir. 1972)	78
Blanks v. *Cunningham*, 409 F.2d 220 (4th Cir. 1969)	72
Board of Regents v. *Roth*, 408 U.S. 564 (1972)	42
Bolling v. *Sharpe*, 347 U.S. 497 (1954)	81
Bradley v. *Fisher*, 80 U.S. 335 (1871)	77
Brady v. *Southern Ry. Co.*, 320 U.S. 476 (1943)	51
Burnham v. *Department of Pub. Health*, 349 F. Supp. 1335 (N.D. Ga. 1972), *rev'd and remanded*, No. 72-3110 (5th Cir. Nov. 8, 1974)	37, 39, 58, 60
Commonwealth v. *Page*, 339 Mass. 313, 159 N.E. 2d 82 (1959)	37
Continental Ore Co. v. *Union Carbide and Carbon Corp.*, 370 U.S. 690 (1962)	51
Davis v. *Watkins*, No. C 73-205 (N.D. Ohio, Sept. 1974)	36, 58
Davy v. *Sullivan*, 354 F. Supp. 1320 (M.D. Ala. 1973)	37
Director of Patuxent Institution v. *Daniels*, 243 Md. 16, 221 A.2d 397, *cert. denied*, 385 U.S. 940 (1966)	37
Dobson v. *Cameron*, 383 F.2d 519 (D.C. Cir. 1967)	66
Doe v. *Bolton*, 410 U.S. 179 (1973)	73

TABLE OF AUTHORITIES—Continued

Page

Donaldson v. *O'Connor*, 493 F.2d 507 (5th Cir. 1974) *passim*
Duignan v. *United States*, 274 U.S. 195 (1927) 76
Easter v. *District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966) 72
Eastman Kodak Co. of New York v. *Southern Photo Materials Co.*, 273 U.S. 359 (1927) 50
Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 44
Galloway v. *United States*, 319 U.S. 372 (1943) 51
In re Gault, 387 U.S. 1 (1967) 51, 52
Gomes v. *Gaughan*, 471 F.2d 794 (1st Cir. 1973) 37
Great No. Ry. v. *Sunburst Oil & Refining Co.*, 287 U.S. 358 (1932) 76
Greenwood v. *United States*, 350 U.S. 366 (1956) 51, 52, 71
Gunning v. *Cooley*, 281 U.S. 90 (1930) 51
Handverger v. *Harvill*, 479 F.2d 513 (9th Cir. 1973), *cert. denied*, 414 U.S. 1072 (1973) 78
Harrison v. *Brooks*, 446 F.2d 404 (1st Cir. 1971) 78
Hawaii v. *Standard Oil Co. of California*, 405 U.S. 251 (1972) 48
Holt v. *Sarver*, 442 F.2d 304 (8th Cir. 1971) 72
Humphrey v. *Cady*, 405 U.S. 504 (1972) 31, 43, 51, 52, 57, 62, 63
Hvotavi v. *Vanderport*, 380 F. Supp. 645 (D. Minn. 1974) 80
Husty v. *United States*, 282 U.S. 694 (1930) 76
In re I, 316 N.Y.S.2d 356 (Fam.Ct. 1970) 37
Inmates of Boys Training School v. *Affleck*, 346 F. Supp. 1354 (D.R.I. 1972) 37
Jackson v. *Indiana*, 406 U.S. 715 (1972) 32, 33, 34, 44, 45, 49, 51, 56, 57, 62, 67
James v. *Strange*, 407 U.S. 128 (1972) 44
Jobson v. *Henne*, 355 F.2d 129 (2d Cir. 1966) 79
In re Jones, 338 F. Supp. 428 (D.D.C. 1972) 66
Jones v. *Perrigan*, 459 F.2d 81 (6th Cir. 1972) 78

TABLE OF AUTHORITIES—Continued

Page

Kesselbrenner v. *Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973) 36
Kirstein v. *Rector & Visitors of University of Virginia*, 309 F. Supp. 184 (E.D. Va. 1970) 80
Landman v. *Royster*, 354 F. Supp. 1302 (E.D. Va. 1973) 72, 79
Lane v. *Wilson*, 307 U.S. 268 (1969) 79
Lawn v. *United States*, 355 U.S. 339, rehearing denied, 355 U.S. 967 (1958) 76
Linkletter v. *Walker*, 381 U.S. 618 (1965) 76
Lumberman's Mutual Casualty Co. v. *Elbert*, 348 U.S. 48 (1954) 51
Lynch v. *Baxley*, Civ. Action No. 74-89-N (M.D. Ala. Dec. 14, 1974) 56
M v. *M*, 71 Misc.2d 396, 336 N.Y.S.2d 304 (Fam. Ct. 1970) 37
Maatallah v. *Warden, Nevada State Prison*, 86 Nev. 430, 470 P.2d 122 (1970) 37
In re Maddox, 351 Mich. 358, 88 N.W.2d 470 (1958) 37
Martarella v. *Kelley*, 349 F. Supp. 575 (S.D. N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D. N.Y. 1973) 37, 52, 58
Martinez v. *Mancusi*, 443 F.2d 921 (2d Cir. 1970), *cert. denied*, 401 U.S. 983 (1971) 72
McCray v. *Maryland*, 456 F.2d 1 (4th Cir. 1972) 78
McKinney v. *DeBord*, 324 F. Supp. 928 (E.D. Cal. 1970) 80
McNeil v. *Director, Patuxent Institution*, 407 U.S. 245 (1972) 51, 57, 67
Meyer v. *Nebraska*, 262 U.S. 390 (1923) 44, 45, 56
Minnesota ex rel. Pearson v. *Probate Court*, 309 U.S. 270 (1940) 41
Mitchell v. *Boslow*, 357 F. Supp. 199 (D. Md. 1973) 78
Morales v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973) 37

TABLE OF AUTHORITIES—Continued

Page

Mormon Church v. *United States*, 136 U.S. 1 (1890) 48
Morrissey v. *Brewer*, 408 U.S. 471 (1972) 43
Murel v. *Baltimore City Criminal Ct.*, 407 U.S. 355 (1972) 51, 57, 62
Nason v. *Superintendent of Bridgewater State Hospital*, 353 Mass. 604, 233 N.E.2d 908 (1968) 37, 62
Nebbia v. *New York*, 291 U.S. 502 (1934) 44, 45, 56
Nelson v. *Heyne*, 355 F. Supp. 451 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352 (7th Cir. 1974) 37
New York State Association for Retarded Children, Inc. v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973) 36, 37
Nixon v. *Herndon*, 273 U.S. 536, 47 S.Ct. 446, 71 L.Ed. 759 (1927) 79
Papachristou v. *City of Jacksonville*, 405 U.S. 156 (1972) 43
Pierson v. *Ray*, 386 U.S. 547 (1967) 77, 78
Powell v. *McCormack*, 395 U.S. 486 (1969) 61
Powell v. *Texas*, 392 U.S. 514 (1968) 52
Ragsdale v. *Overholser*, 231 F.2d 943 (D.C. Cir. 1960) 53
Renelli v. *Department of Mental Hygiene*, 340 N.Y.S.2d 498 (1973) 36
Robinson v. *California*, 370 U.S. 660 (1962) 52, 53, 60, 72
Roe v. *Wade*, 410 U.S. 113 (1973) 42, 44, 55, 72
Rouse v. *Cameron*, 373 F.2d 451 (D.C. Cir. 1966) 66
Sas v. *Maryland*, 334 F.2d 506 (4th Cir. 1964) 37
Scheuer v. *Rhodes*, 416 U.S. 232 (1974) 77, 78, 79
Shapiro v. *Thompson*, 394 U.S. 618 (1969) 43, 55
Shelton v. *Tucker*, 364 U.S. 479 (1960) 43, 55
Silvers v. *People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970) 37
Southwestern Brewery & Ice Co. v. *Schmidt*, 226 U.S. 162 (1912) 50

TABLE OF AUTHORITIES—Continued

Page

Specht v. *Patterson*, 386 U.S. 605 (1967) 52
Stachulak v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973) 37
Strickland v. *Inlow*, 485 F.2d 186 (8th Cir. 1973), *cert. granted, sub. nom. Wood* v. *Strickland*, 42 U.S.L.W. 3584 (No. 73-1285, Apr. 15, 1974) 83
Taylor v. *Perini*, 365 F. Supp. 557 (N.D. Ohio 1972) 80
Tenney v. *Brandhove*, 341 U.S. 367 (1951) 77
Tribby v. *Cameron*, 379 F.2d 104 (D.C. Cir. 1967) 66
Truax v. *Raich*, 239 U.S. 33 (1915) 43
United States v. *Jackson*, 306 F. Supp. 4 (N.D. Cal. 1971) 53
United States v. *Klein*, 325 F.2d 283 (2d Cir. 1963) 72
United States v. *Pardue*, 354 F. Supp. 1377 (D. Conn. 1973) 37
United States v. *Solomon, et al.*, Civ. Act. No. 74-181 (D. Md., filed Feb. 21, 1974) 36
United States v. *Walker*, 335 F. Supp. 705 (N.D. Cal. 1971) 37, 53
Vlandis v. *Kline*, 412 U.S. 441 (1973) 44, 45, 56
Welsch v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) 36, 53, 58, 65, 68
Wheeler v. *Glass*, 473 F.2d 983 (7th Cir. 1973) 78, 79
Whirl v. *Kern*, 407 F.2d 781 (5th Cir. 1969), *cert. denied*, 396 U.S. 901 (1969) 81, 83
Whitetree v. *State*, 56 Misc.2d 693, 290 N.Y.S.2d 486 (Ct.Cl. 1968) 72
Williamson v. *Lee Optical Co.*, 348 U.S. 483 (1955) 44
In re Winship, 397 U.S. 358 (1970) 31, 43
Winters v. *Miller*, 446 F.2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971) 80
Wright v. *McMann*, 460 F.2d 126 (2d Cir. 1972) 80, 84

TABLE OF AUTHORITIES—Continued

Page

Wyatt v. *Aderholt*, No. 72-2634 (5th Cir., Nov. 8, 1974) 36, 39, 53, 65, 68
Wyatt v. *Stickney*, 325 F. Supp. 781 (M.D.Ala. 1971), *aff'd, sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Nov. 8, 1974) 36, 53, 58, 66
Wyatt v. *Stickney*, 334 F. Supp. 1341 (M.D.Ala. 1971) 68
Wyatt v. *Stickney*, 344 F. Supp. 387 (M.D.Ala. 1972) 36, 58
York v. *Story*, 324 F.2d 450 (9th Cir. 1963) 80
Zenith Radio Corp. v. *Hazeltine Research, Inc.*, 395 U.S. 100 (1969) 51

Constitution:

Eighth Amendment 52, 56, 60
Fourteenth Amendment ..... *passim*

Statutes:

18 U.S.C. § 4246 72
42 U.S.C. § 1983 77
Arizona Leg. Services (1973) (Ch. 185) §§ 36-518 and 36-523 85
Connecticut General Statutes Annotated (Supp. 1974) §§ 17-206c and 17-206h 85
D.C. Code Annotated §§ 21-562 and 21-591 (1973) 85
27 Florida Statutes Annotated §§ 394.08, 394.09, 394.21, 394.22, 394.201 and 394.272 (1941) (repealed July 1, 1972) 3, 4, 6, 15, 41, 45
27 Florida Statutes Annotated §§ 394.459, 394.467 and 394.469 ..... 70, 85
Georgia Code Annotated (1971) §§ 88.502.3 and 88.502.18 85

Miscellaneous:

American Bar Foundation, The Mentally Disabled and the Law (S. Brakel & R. Rock, eds.) (rev. ed. 1971) 33, 34, 41, 46, 49, 54, 55, 63

TABLE OF AUTHORITIES—Continued

Page

American Psychiatric Association, Position Paper on Involuntary Hospitalization of the Mentally Ill (Revised), 130 Am. J. Psychiatry 392 (March, 1973) 67
American Psychiatric Association, Standards for Psychiatric Facilities (1969) 46, 69
American Psychiatric Association, Standards for Psychiatric Facilities (1974 Revision/Addendum) 66, 69
American Psychiatric Association, Task Force on the Right to Care and Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded (4th Draft, October, 1974) 35, 67
American Psychological Association, Task Force on the Standards for Service Facilities, Standards for Providers of Psychological Services (September, 1974) 67
R. Barton, Institutional Neurosis (2d ed. 1966) 42
I. Belknap, Human Problems of State Mental Hospitals (1956) 42
Birnbaum, *The Right To Treatment*, 46 A.B.A.J. 499 (1960) 35
By-Laws, Rules and Regulations of the Medical Staff of the Florida State Hospital (1967) 4, 7, 10, 46, 47
Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282 (1973) 35, 38, 53, 58, 61, 63, 68
Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1107 (1972) 35, 42
Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190 (1974) 35, 41, 42, 48, 49, 55, 56, 58, 61, 68, 71

TABLE OF AUTHORITIES—Continued

Page

Committee on State Institutions, Florida, Final Report of the General Findings of the Committee on State Institutions Relating to the Conditions at Florida State Hospital and the Alleged Mistreatment of Patients (May 1, 1961) 30

D. Dawidoff, The Malpractice of Psychiatrists (1973) 72

A. Deutsch, The Mentally Ill in America (2d ed. 1949) 34

A. Deutsch, The Shame of the States (1948) 34

Drake, *Enforcing the Right to Treatment*, 10 Am. Crim. L. Rev. 587 (1972) 36

Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A.J. 1371 (1974) 46, 49, 55

Florida Division of Mental Health, Manual of Rights of Patients, January, 1974 ..... 71, 85

E. Goffman, Asylums: Essays on the Social Situation of Mental Patients and Other Inmates (1961) 34, 42

Goodman, *Right to Treatment: The Responsibility of the Courts*, 56 Georgetown L. J. 680 (1969) 36

Gruenberg, *The Social Breakdown Syndrome—Some Origins*, 123 Am. J. Psychiatry 12 (June, 1967) 42

Gunther, *Foreword: In Search of Evolving Doctrine on A Changing Court: A Model for Newer Equal Protection*, 86 Harv. L. Rev. 1 (1972) 44

M. Guttmacher and H. Weihoffen, Psychiatry and the Law (1952) 34

Hearings on Constitutional Rights of the Mentally Ill Before the Subcommittee on Constitutional Rights of the Senate Comm. on the Judiciary, 87th Cong., 1st Sess. (1961) 34, 42, 46

TABLE OF AUTHORITIES—Continued

Page

Hearings on Constitutional Rights of the Mentally Ill Before the Subcommittee on Constitutional Rights of the Senate Comm. on the Judiciary, 91st Cong., 1st and 2d Sess. (1969-70) 34

Joint Commission on Accreditation of Hospitals, Accreditation Council for Psychiatric Facilities, Accreditation Manual for Psychiatric Facilities (1972) 66, 69

Joint Commission on Mental Illness and Health, Action for Mental Health (1961) 34

Joint Information Service and the American Psychiatric Association and the National Association for Mental Health, Fifteen Indices: An Aid in Reviewing State and Local Mental Health Programs (1966) 35

J. Katz, J. Goldstein, and A. Dershowitz, Psychoanalysis, Psychiatry and Law (1967) 71, 72

Katz, *The Right to Treatment—An Enchanting Legal Fiction*, 36 U. Chi. L. Rev. 755 (1969) 36

Mental Health Law Project and Practising Law Institute, Legal Rights of the Mentally Handicapped (B. Ennis & P. Friedman, eds. 1973) 34

5A J. Moore, Federal Practice (2d ed. 1974) 50, 51

Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Law. 133 (1972) 35

National Association for Mental Health, Position Statement on Right to Treatment (October, 1970) 67

National Center for Mental Health Services, Training and Research, NIMH, NCM-SEH Patient Inventory (April, 1970) 38

Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv. L. Rev. 1288 (1966) 48, 49

Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 Yale L. J. 87 (1967) 36

TABLE OF AUTHORITIES—Continued

Page

Note, *The Nascent Right to Treatment*, 53 Va. L. Rev. 1134 (1967) 34, 36, 48, 49, 52, 58, 63
Note, *The Rights of the Mentally Ill During Incarceration: The Developing Law*, 25 U. Fla. L. Rev. 494 (1973) 35
Patient No. A-25738 (Donaldson), *The Right to Treatment Inside Out*, 57 Georgetown L. J. 194 (1969) 21
Robitscher, *The Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 Vill. L. Rev. 11 (1972) 35
R. Rock, M. Jacobson, and R. Janopaul, Hospitalization and Discharge of the Mentally Ill (1968) 34
D. Rothman, The Discovery of the Asylum (1971) 33, 34, 54
Schwitzgebel, *The Right to Effective Mental Treatment*, 62 Calif. L. Rev. 936 (1974) 67
R. Slovenko, Psychiatry and Law (1973) 71, 72
Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 Am. J. Psychiatry (1958) 34, 35
L. Tribe, Channeling Technology Through Law (1973) 73
Tribe, *Foreward—Toward a Model of Roles in the Due Process of Life and Law*, 86 Harv. L. Rev. 1 (1973) 44
Wexler, *Mental Health Law and the Movement Toward Voluntary Treatment*, 62 Calif. L. Rev. 671 (1974) 55
J. Wing and G. Brown, Institutionalism and Schizophrenia (1970) 42
9 C. Wright and A. Miller, Federal Practice and Procedure (1971) 50, 51

IN THE

Supreme Court of the United States

OCTOBER TERM 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner

v.

KENNETH DONALDSON,
Respondent

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR THE RESPONDENT

OPINION BELOW

The Opinion of the Court of Appeals for the Fifth Circuit is reported at 493 F.2d 507.

QUESTIONS PRESENTED

1. Did respondent, who was involuntarily confined to a mental hospital for the purpose of treatment for nearly fifteen years, and who was dangerous neither to himself nor to others, have a constitutional right to be restored to liberty either by treatment or release?

2. Is there no evidence from which the jury could have concluded, as it did, that petitioner did not reasonably believe in good faith that respondent's continued confinement was lawful or proper, and that petitioner's acts were sufficiently malicious, wanton and oppressive to justify both compensatory and punitive damages?

STATEMENT OF THE CASE

A. Introduction

Petitioner O'Connor deprived respondent Donaldson of his liberty for nearly fifteen years, even though he was under no statutory or judicial obligation to do so. He did so even though he knew respondent was not dangerous to himself or to others. He did so even though he knew respondent was receiving only the same custodial care he would have received in a prison. And, having the authority to release respondent, he instead blocked respondent's efforts to be released to the custody of responsible friends and organizations. His acts, as a jury found, showed bad faith, and were so malicious, wanton and oppressive as to justify not only compensatory damages of $17,000, but punitive damages of $5,000.

Properly understood, this case raises important but narrow issues. In order to identify issues that are, and are not, raised by this case, it will be necessary to review the extensive facts developed at trial in some detail. Many of the "facts" contained in petitioner's brief are unsupported by any citations, and have literally no basis in the record. And petitioner has ignored material facts that were overwhelmingly established at trial.

B. Facts

From the evidence of record, the jury could reasonably have found the following facts:

1. Respondent was committed to Florida State Hospital in January, 1957 for the purpose of treatment.

Respondent's commitment papers, which accompanied him to Florida State Hospital, expressly stated that respondent was committed "to the Superintendent of the Florida State Hospital, Chattahoochee, Florida, for care, maintenance *and treatment*." Plaintiff's Exhibit No. 13, "Order for Delivery of Mentally Incompetent." (Emphasis added.)

That order, by itself, made it clear that respondent was to receive something more than mere custodial care. The order, in turn, was consistent with, and required by, the statutes in effect at the time of respondent's commitment, which leave no doubt that the statutory purpose of his confinement was treatment.

Title 27 Florida Statutes § 394.09 (Laws 1877, Ch. 3036 § 1) (repealed July 1, 1972), then in effect, provided that persons committed to "hospitals" were committed "for the purpose of care, custody *and treatment*. . . ." (Emphasis added.) The word "treatment" was not fortuitous. The same section provided that persons committed not to hospitals but to "any other person" were committed "for care, custody or maintenance. . . ."[1]

---

[1] Title 27, Florida Statutes, § 394.21(1) (Laws 1945, Ch. 23157 § 3) (repealed July 1, 1972) provided that the "head of a hospital" could admit involuntary patients "for observation, diagnosis, care *and treatment* . . . ." (Emphasis added.) Title 27, Florida Statutes, §§ 394.21(6) and 394.22(13) (repealed July 1, 1972) authorized recovery from the estates of patients of "reasonable charges" for the "care, maintenance *and treatment*" of patients, and provided that advance payment could not be "a prerequisite to the care, maintenance *and treatment*" of patients in public hospitals. (Emphasis added.) In order to implement this legislative purpose, Title 27, Florida Statutes § 394.08 (Laws 1945, Ch. 22858 § 7) (repealed July 1, 1972) required the "superintendent of the Florida State Hospital" (that is, petitioner, for 7½ years of the period respondent was confined) to "cause" the chief physician to "keep a com-

In addition, in 1967, four years before respondent was discharged, petitioner promulgated the *By-Laws. Rules and Regulations of the Medical Staff of the Florida State Hospital* (cited hereafter as "Hospital Regulations"). Plaintiff's Exhibit 2, and answers 14-a, 14-b and 15 of petitioner's *Answers to Interrogatories* dated January 4, 1972. The Hospital Regulations (at 4) stated that Florida State Hospital "was established to provide a *treatment facility* for the mentally ill in the State of Florida," and provided further:

> "Generally, it is our responsibility to the patients *to provide the best psychiatric and physical care possible.* It is expected that all physicians shall, at all times, conform with the ethical standards of medical practice. *Our primary objective is to return the patients as useful citizens, to their own community, as soon as possible. The mental hospital should only be an intermediate step in the treatment and rehabilitation of the patient.* Aside from providing the *best standards of treatment*, it is the responsibility of every physician to encourage and participate in whatever hospital programs in which he is asked to participate." Hospital Regulations at 54. (Emphasis added.)

The Hospital Regulations stated that the "*superintendent is responsible* . . . for the proper management of the hospital in order *to insure the best possible care and treatment* for the patients." Hospital Regulations at 55. (Emphasis added.)

---

plete clinical record of each patient, which record shall contain the name of the patient, the diagnosis, the date of beginning of *each treatment*, each day's prescription while under *treatment*, and such other therapy as may be indicated." (Emphasis added.) Subsequent statutes, effective in 1965 and 1967 (respondent was released July 31, 1971), continued to speak in terms of "treatment." *E.g.*, Title 27, Florida Statutes, §§ 394.272 (Laws 1965, Ch. 65-23 § 1) and 394.201 (6)(a) and (b) (Laws 1967, Ch. 67-7 § 4) (repealed July 1, 1972).

In summary, the court order which committed respondent, the statutes under which he was committed, and the Hospital Regulations all show that respondent was confined for the purpose of treatment.

2. Petitioner knew that respondent received no treatment, and that respondent received only custodial care.

Respondent's first witness was Dr. Walter Fox, an unusually distinguished psychiatrist, who had intimate knowledge of the standards applicable in public mental hospitals during the period of respondent's confinement.[2] Dr. Fox was asked, for the period 1957-1967, if there was evidence in respondent's hospital record that respondent "received psychiatric treatment." He replied (A at 2; T 11/21/72 at 65-66):[3]

> "A. No. In my opinion *there is no evidence that he received psychiatric treatment.* There are a number of progress notes which are generally brief and which make no reference to a treatment plan which frequently refer to continue custodial care or words

---

[2] At the time of trial, Dr. Fox was Director of Mental Health Services for the state of Arizona. He had served as superintendent of public mental hospitals in Kentucky (1956-1965) and Iowa (1966-1972), and for two years as President of the Association of Medical Superintendents of Mental Hospitals (1968-1970). Accordingly, he was intimately familiar with the problems and the capacities of public mental hospitals during the period respondent was confined, and his evaluation of respondent's hospital record was made in that context. Dr. Fox is a Diplomat in Psychiatry of the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association. T11/21/72 at 59-64.

[3] "A" refers to the Appendix. "T" refers to the transcript of trial. Because there are several transcripts, each for a separate day of trial, and they are not all consecutively paginated, citations to the transcript are followed by the date of the particular transcript to which reference is being made. There are two transcripts for the final day of trial. The one which primarily reproduced the "oral charge" to the jury is so designated (T Oral Charge 11/28/72). "H" refers to respondent's hospital record, which was received in evidence as Plaintiff's Exhibit No. 1.

to that effect, which I interpret to mean provide food, clothing and shelter, and that is not psychiatric treatment." (Emphasis added.)

The very first progress note in respondent's hospital record, written nearly three months after admission by co-defendant John Gumanis, says "continue custodial care." A at 199; H at 64. That note was written while petitioner was respondent's attending physician, and thus directly in charge of respondent's care. Petr. Brief at 6. Twenty-one months later, in another progress note, co-defendant Gumanis repeated the order to "continue custodial care." A at 199(a); H at 64. Similar orders to continue custodial care were written by co-defendant Gumanis on March 21, 1959, April 23, 1959 (all while petitioner was respondent's attending physician), and on April 3, 1962. A at 200(b); H at 64-65. According to a progress note signed by a Dr. Chacon on August 30, 1965, nearly nine years after his admission, respondent was still receiving only "custodial care." A at 201(a)(i); H at 67. Gumanis testified, and petitioner did not deny, that custodial care would not help a paranoid schizophrenic, the diagnosis applied to respondent by petitioner. A at 113-14; T 11/27/72 at 38. A co-defendant, Dr. Walls, testified that respondent only received "milieu therapy," and that "custodial care is what we now call milieu therapy." A at 142-43; T 11/27/72 at 118-20. A letter Walls wrote on June 2, 1970, confirms this is what "milieu therapy" meant at Florida State Hospital. H at 838-40.

Petitioner knew that an adequate hospital record, containing an individualized treatment plan and frequent progress notes, is an essential prerequisite to treatment, and he knew that respondent's hospital record was inadequate (*see*, Florida Statutes § 394.08, note 1, *supra*,

requiring a "complete clinical record"), and could not serve as the basis of a treatment program.[1]

Dr. Fox, who in the previous two years had been called upon as a "consultant for the National Institute of Mental Health" to examine 400-500 patient records "to determine whether or not they were adequate records," and "whether or not the patients described in those records were receiving adequate treatment," testified that respondent's record was not an adequate record. A at 1, 10; T 11/21/72 at 64-65, 77-78. For example, Dr. Fox testified that he found "no evidence" of an "individualized treatment plan" in respondent's hospital record during the first ten years of his confinement (A at 4; T 11/21/72 at 69), even though "a treatment plan is basic to discharging a person." A at 10; T 11/21/72 at 78. Petitioner testified that respondent's treatment plan "would be incorporated no doubt in progress notes made by the patient's attending physician." A at 172; T 11/28/72 at 46. But during the period he was respondent's attending physician, petitioner did not "incorporate" a treatment plan in respondent's progress notes. In fact, he entered *nothing* in respondent's record. A co-defendant testified that it was petitioner's practice not to make "any notes." A at 105; T 11/27/72 at 11.

---

[1] The Hospital Regulations promulgated by petitioner provided that "the attending physician shall be responsible for an adequate record of the patient . . . ." Article XI, ¶ 7. The specified purpose of the Hospital Regulations was "to insure that all patients admitted to the hospital receive the best possible care." Article II, ¶ 1. To that end, the Regulations required that an "individual comprehensive treatment plan [be] recorded, based on an inventory of the patient's strengths as well as his disabilities . . . ." Article VII, § 8, ¶ 5, Factor 8. The individual treatment plan was required to include "a substantiated diagnosis," "short-term and long-range goals, and the specific treatment modalities utilized as well as the responsibilities of each member of the treatment team in such a manner that it provides adequate justification and documentation for the diagnosis and for the treatment and rehabilitation activities carried out." *Id.*

That practice, according to Dr. Fox, was contrary to the "standard practice in mental hospitals" under which a note would be entered in the record after each "significant contact" with a patient. A at 11-12; T 11/21/72 at 79.

The most vivid description of the prison-like custodial conditions in which he was forced to live from 1957 to 1967 comes from respondent's testimony (A at 40-44; T 11/22/72 at 245-48):

"Q. Now, in the buildings you lived in in Department A, were those buildings locked?
A. Yes, sir.
Q. Were the wards you lived on locked?
A. Yes.
Q. Were there metal enclosures on the windows?
A. Yes, padlocks on each window.
Q. Approximately how many beds were there in the rooms where you slept?
A. Some sixty beds.
Q. How close together were they?
A. Some of the beds were touching, the sides touched, and others there was room enough to put a straight chair if we had had a chair.
Q. Did you have chairs in the dormitory areas?
A. There wasn't a chair in the room I was in.
Q. All right, was there an outside exercise yard for your department?
A. Yes, there was a space outside the building, a good sized space enclosed with a cyclone fence topped with barbwire.
Q. Did you go out to that exercise yard?
A. I went out from time to time when the other patients went out.
Q. Was there ever a period of time when you did not go out to the exercise yard?
A. Yes, there was one period in particular when nobody went out for two years.

Q. Now, Mr. Donaldson, you were civilly committed. You had not been charged with any crime, is that right?
A. That is right.
Q. Were there criminal patients on your ward?
A. There were criminal patients on the ward.
Q. Approximately what percent of the population on your ward were criminals?
A. Looking back, roughly, I would say a third. I do not know the figures for the whole department.
Q. Let's talk just about your ward.
A. Okay. I would say about a third in the wards I was in.
Q. Now, did you sleep in the same rooms as the criminal patients?
A. Yes.
Q. Did you get up at the same time?
A. Yes.
Q. Did you eat the same food?
A. Yes.
Q. In the same dining room?
A. Yes.
Q. Did you wear the same clothes?
A. Yes. The entire operation of the wards I was on was geared to the criminal patients.
Q. Let me ask you, were you treated any differently from the criminal patients?
A. I was treated worse than the criminal patients.
Q. In what sense were you treated worse?
A. The criminal patients got the attention of the doctors. Generally a doctor makes a report to the court every month.
Q. For the criminal?
A. On the criminal patients, and that would be a pretty heavy case load. It didn't give them time to see the ones who weren't criminal patients.
Q. Was there a place on the ward you had access to for keeping personal possessions?
A. No, not at that time.

Q. What did you do with your personal possessions?
A. I kept mine in a cedar box under the mattress of my bed.
Q. Was there a place in the wards where you could get some privacy?
A. No, not anytime in all of the years I was locked up.
Q. Were you able to get a good night's sleep?
A. No.
Q. Why not?
A. On all of the wards there was the same mixture of patients. There were some patients who had fits during the night. There were some patients who would torment other patients, screaming and hollering, and the fear, always the fear you have in your mind, I suppose, when you go to sleep that maybe somebody will jump on you during the night. They never did, but you think about those things. It was a lunatic asylum."

Accordingly, the jury could have concluded that petitioner knew respondent lived on a locked ward, with criminal patients, and received only the "custodial care" he would have received in a prison.

3. Despite the inadequate staffing and resources at Florida State Hospital, there were standard modes of treatment that were available, but were not provided for respondent.

Petitioner knew respondent did not receive even those types of treatment that *were* available at Florida State Hospital.

Grounds privileges. Since the express goal of hospitalization, as stated in the Hospital Regulations, was to restore the capacity for independent community living, one of the most basic forms of treatment was to give patients an increasing degree of independence and personal responsibility. Co-defendant Walls confirmed that

Florida State Hospital "often" gave "grounds privileges" to the involuntary male patients, which allowed them to walk around the hospital's extensive grounds unattended. T 11/27/72 at 106. Dr. Fox testified that confining respondent to a locked building, with no opportunity for grounds privileges, was inconsistent with a psychiatric treatment plan for him. A at 4; T 11/21/72 at 70. Further, even in "an institution with limited resources" it would have been "standard psychiatric practice . . . in the case of Mr. Donaldson" to give him "grounds privileges," "weekend passes" and "trial visits for a month or two." A at 13-14; T 11/21/72 at 80-81.

Twice in 1957 petitioner approved respondent's assignment to institution-maintaining work assignments but crossed out that portion of the work assignment forms which would have given respondent grounds privileges while on the way to and from work. A at 193(a)-(b); H at 13-14.[5] Respondent specifically requested grounds privileges, but co-defendant Gumanis denied his request. T 11/22/72 at 240-41; A at 200(b); H at 65. Gumanis testified that the decision to deny grounds privileges was made in consultation with petitioner. A at 118; T 11/27/72 at 42. In fact, Gumanis testified that respondent "never" had grounds privileges during his ten years in Department A because Gumanis "consulted the superintendent" (petitioner), who "advised" Gumanis "not to give any." A at 118; T 11/27/72 at 42. No reason for the denial is contained in the hospital record and, although the matter was in dispute, no explanation was offered at trial. When respondent later came under Dr. Hanenson's care in Department C, Dr. Hanenson gave him grounds privileges. T 11/22/72 at 271.

[5] Copies of various documents retyped by petitioner for use in the Appendix are incomplete or inaccurate. For example, petitioner's signature and the denial of grounds privileges show quite clearly on the original work forms but do not show up on the retyped copies of the work forms used in the Appendix.

Occupational Therapy. Dr. Fox also testified that even with the "limited resources" of Florida State Hospital, petitioner could have assigned respondent to Occupational Therapy, which, given respondent's "social history," would have been an "excellent" treatment mode. A at 14-15; T 11/21/72 at 81-82.[6] Petitioner admitted that the hospital had a "well-regulated occupational therapy program" (T 11/28/72 at 36), and he knew from the hospital record (A at 201(i)) that his co-defendant Gumanis had denied respondent's request to be assigned to Occupational Therapy. No reason for the denial is contained in the hospital record and, although the matter was in dispute, no explanation was offered at trial. Within a month of his transfer to Dr. Hanenson's care (A at 202(b)(i); H at 70), respondent was permitted to engage in Occupational Therapy. *Id.*; T 11/22/72 at 271.

Contacts with physicians. Petitioner also knew that respondent's contacts with physicians were infrequent and administrative rather than therapeutic in nature. According to respondent's testimony, which petitioner did not dispute, during the period that petitioner was "directly responsible" for respondent's care, petitioner only spoke to respondent six times, less than one hour in all, and asked only the same three questions in each interview. T 11/22/72 at 216-19, 224, 241. The questions were: "What ward are you on?" "Are you taking any medication?" "Are you working any place?" A at 36; T 11/22/72 at 241. Respondent testified, again without contradiction, that he requested permission "many times" to speak with petitioner, but petitioner refused to speak with him. A at 38-39; T 11/22/72 at 243-44. Even if petitioner refused to speak with respondent only because petitioner was overworked (and there is no claim or evidence that that was the reason), the refusals surely demonstrate petitioner's awareness that respondent rarely spoke with physicians. In fact, the refusals are relevant not only to show that petitioner knew respondent was not receiving treatment, but also as evidence of petitioner's bad faith. As petitioner testified, there were "numerous opportunities [for the attending psychiatrist] to work out the patient's problems." T 11/28/72 at 35. Thus, the jury could have concluded that at least some of petitioner's refusals to speak with respondent could constitute evidence of bad faith.

[6] The work respondent performed was not the equivalent of occupational therapy, which teaches patients new employment skills. Petitioner never claimed that respondent's work assignments were, or were intended to be, therapeutic. Nor could he. Respondent's work requests were initiated by non-medical staff (*see*, H at 13-14), and were solely for the benefit of the institution. Respondent received no pay, and performed only menial tasks, such as dumping garbage, mopping floors, making beds, digging ditches, and helping retarded residents take showers. A at 45-51; T 11/22/72 at 249-54. The work assignments made it impossible for respondent to participate in occupational therapy, group therapy, or other treatment modes. For example, during his kitchen assignment, respondent worked "seven days a week" "from 6:00 o'clock in the morning to 7:00 o'clock that night," and was "locked in the kitchen all of that time." A at 48; T 11/22/72 at 252.

Social Services. Petitioner testified that the patient's physician "could, at his discretion, be aided by the efforts of a social service worker . . . ." T 11/28/72 at 35. But petitioner chose not to use that available service. In 1958, the Social Service Department received a letter from respondent stating he was not "receiving treatment of any kind." A at 206(a); H at 238. The Social Service Department brought that claim to petitioner's attention and asked if petitioner wanted "to refer this patient to Social Service." A at 206(b); H at 239. Even after this express offer, petitioner declined to utilize the proferred services of the Social Service Department. A at 206(b); H at 239.

In response to the overwhelming evidence that respondent received no treatment, and did not receive even those forms of treatment that were available, petitioner *now*

claims, although he did not so claim or testify at trial, and cites in his brief to no evidence in the record to support that claim, that respondent "did participate in milieu therapy, religious therapy and recreational therapy." Petr. Brief at 10. Respondent has shown that, at Florida State Hospital, "milieu therapy" meant no more than "custodial care." A at 142-43. Petitioner's co-defendant John Gumanis conceded at trial that "religious therapy" meant that respondent "could have gone to church," and that "recreational therapy" meant little more than that respondent "could have amused himself any way he wanted." A at 96-97; T 11/22/72 at 470-71. Even if religion and recreation could be considered "therapy," and were available for other patients, there is no indication in respondent's hospital record that such therapies were ever prescribed for respondent. To the contrary, at least to the extent that physical exercise is a form of recreation, there was evidence that for two years respondent was not even permitted to "go out to the exercise yard." A at 41-42.

From this evidence the jury could have concluded that petitioner knew respondent did not receive even those modes of treatment that were available at Florida State Hospital, and that petitioner even "unjustifiably withheld . . . specific forms of treatment" from respondent. 493 F.2d at 513.

4. Petitioner knew respondent was not dangerous to himself or to others.

As respondent will demonstrate *infra* (pp. 39-40), under the instructions in this case, the jury could not have returned a verdict for respondent unless it first found that respondent was not dangerous to himself or to others, and that petitioner *knew* that respondent was not dangerous. There was ample evidence to support that finding.

The trial court did not determine whether, under Florida law, a finding of dangerousness was prerequisite to involuntary and indeterminate commitment, and the commitment papers which accompanied respondent to Florida State Hospital (Plaintiff's Exhibit No. 13) are sketchy and inconsistent on the issue of dangerousness.[7] However, even if the commitment papers could have justified a belief that respondent was dangerous at the time of commitment, petitioner knew that it was his responsibility to review whether respondent continued to be dangerous.[8]

Following respondent's hospitalization, the evidence that he was not, in fact, dangerous to himself or to others,

---

[7] Respondent was committed under Title 27, Florida Statutes, § 394.22(11)(a): "Whenever any person who has been adjudged mentally incompetent requires confinement or restraint to prevent self-injury or violence to others, the said judge *shall* direct that such person be committed . . . ." (Emphasis added.) Thus, the judge was *required* to commit dangerous persons, but he may have had the *authority* to commit non-dangerous persons. The commitment papers, though inconsistent and composed primarily of "boiler-plate," suggest that respondent might have been committed even though he was not considered to be dangerous. For example, the actual "Order For Delivery" of respondent to Florida State Hospital provided that respondent required "confinement or restraint to prevent self-injury or violence to others, *or* to insure proper treatment . . . ." Plaintiff's Exhibit No. 13. (Emphasis added.) Thus, respondent may have been committed solely to insure proper treatment. Respondent did not challenge his original commitment, but it should be emphasized that respondent did not, and does not, concede that he was dangerous at the time of commitment. It was not necessary to litigate that issue because under the theory of this case the jury had only to find that *after* commitment respondent was not dangerous, and petitioner knew he was not dangerous.

[8] Petitioner conceded that although the hospital superintendent need not "question the right or wisdom of a court in committing a patient," it was the "duty" of the superintendent "to determine whether the patient having once reached the hospital was in such condition as to suggest that he be considered for release from the hospital." A at 164-65; T 11/28/72 at 24; there is a typographical error in the retyped copy of p. 24 used as p. 165 of the Appendix.

was overwhelming. Petitioner admitted he had no knowledge or recollection that respondent had ever injured anyone, or been arrested for or convicted of any crime. A at 128; T 11/27/72 at 84. Petitioner had neither personal nor second-hand knowledge of *any* occasion during respondent's hospitalization when he either committed or threatened to commit any act that was or would have been dangerous to himself or others, and admitted that "as far as I know, plaintiff was not harming anyone else." A at 127; T 11/27/72 at 82. Letters petitioner wrote[9] stated that respondent was "cooperative" (H at 182), and "causes no particular trouble in management." H at 185. In 1957, petitioner approved respondent's assignment to work in the kitchen, and expressed no concern that respondent would thereby gain access to knives and other dangerous implements. A at 193(b); H at 14.[10]

Experts testified that there was "no evidence" anywhere in respondent's hospital record to indicate that he "ever hit anyone or ever even threatened anyone verbally" (A at 3; T 11/21/72 at 69; Dr. Walter Fox); and that "the overwhelming impression of the test results and the hospital record was of non-violent behavior and non-probability of any kind of acting out behavior." A at 65; T 11/22/72 at 395; Dr. Raymond Fowler.[11]

---

[9] The initials below the signature block on carbons of letters written at Florida State Hospital are the initials of the person who dictated or wrote the letter. Defendants' Exhibit 4, p. 8; T 11/22/72 at 456. Thus, while the letters referred to in text were signed by the Clinical Director, petitioner wrote them, as the JBOC initials indicate.

[10] Also, petitioner apparently read a hospital form (H at 220) which stated that respondent was not considered to be dangerous. T 11/27/72 at 82; H at 221-223.

[11] At the time of trial, Dr. Fowler, a Ph.D. psychologist, was Chairman of the Psychology Department at the University of Alabama, and past President of the Alabama Psychological Association and the Southeastern Psychological Association. He was a member of the Council of Representatives of the American Psychological Association (APA), and a Fellow and Diplomat of APA. He had developed a computer system for the scoring of the Minnesota Multiphasic Personality Index ("MMPI") that had been used by "approximately a third of the psychiatrists in private practice" in the United States, and that was used to grade or diagnose "about 75,000 [patients] a year." Dr. Fowler was qualified as an expert in clinical psychology, particularly in the field of interpreting the MMPI and other psychological tests. T 11/22/72 at 373-82.

Petitioner was intimately familiar with respondent's case and record,[12] and the jury could have concluded that he must have been aware of the uniform opinion of those who dealt with him that respondent was not dangerous. Co-defendant Gumanis conceded he did not think respondent was dangerous. A at 120-21; T 11/27/72 at 44. Julian Davis, Director of the Psychology Department at Florida State Hospital, confirmed at trial (T 11/22/72 at 364-65) his earlier opinion, expressed in a psychological report (H at 62), that respondent was not dangerous and that continued hospitalization was unnecessary. Co-defendant Walls, a psychiatrist at Florida State Hospital, agreed that respondent was not physically dangerous to self or others. A at 141; T 11/27/72 at 118, 126. And a Dr. Rodriguez confirmed in a progress note in February, 1971 that respondent had "never been a violent patient." A at 205(a).

John H. Lembcke, a Certified Public Accountant, college classmate, and close friend of respondent and his family for 46 years (T 11/21/72 at 119-20), who had personally discussed respondent's case with petitioner (T 11/21/72 at 125), testified that respondent was a "gen-

---

[12] Petitioner wrote all outgoing correspondence concerning respondent from March 30, 1957 to July 15, 1959. H at 180-259. And from October 12, 1959 (H at 264) through June 25, 1963 (H at 496) virtually all correspondence concerning respondent went out over petitioner's signature. *See also*, as additional evidence of petitioner's continuing and extensive involvement with respondent's case, H at 67, 68-69, 382-83, 407, 482, 525, 538, 539, 554, 576, 656, 662, 679, and 749.

tle" man who had never been "violent," "belligerent," or "aggressive." T 11/21/72 at 133-34. Finally, respondent testified that he had never injured or threatened to injure himself or others. A at 34; T 11/21/72 at 179.

In summary, as the Court of Appeals noted, "there was no evidence in the record of Donaldson's ever having been violent in any way . . . the jury would have been justified in finding that Donaldson was non-dangerous, and in inferring that the defendants knew him to be so." 493 F.2d at 517.[13]

[13] Moreover, the jury could have found that respondent showed bad faith in falsely representing to others that other staff members considered respondent to be dangerous. For example, at the end of a staff conference on January 9, 1964, petitioner summed up by saying that the "consensus of opinion" was that respondent was "considered to be dangerous to others." A at 196(a); H at 33. However, co-defendant Gumanis, who had directed that staff conference (A at 195; H at 32), testified that the statement that respondent was dangerous was petitioner's "personal opinion." A at 81; T 11/22/72 at 447. No other doctor had expressed that opinion, as the stenographic record of the meeting reveals (A at 195-196(a); H at 32-33), and no evidence of dangerousness had been presented to the staff. T 11/22/72 at 447-49. Dr. Walter Fox, after reviewing the records of the staff conference, pointed out that petitioner, "the last person to speak," was "the first one to use the word dangerous," which petitioner then falsely described as the "consensus of opinion". T 11/21/72 at 111-14. When asked about that statement, petitioner, who admitted he had no personal knowledge that respondent was dangerous (A at 127-28; T 11/28/72 at 82-84), claimed that he was only "summing up the consensus of opinion expressed by others on the staff" and the opinion "of Doctor Franklin Calhoun, the psychologist from Jacksonville who examined the patient." A at 131-32; T 11/28/72 at 87-88. Of course, according to Gumanis and to the staff minutes, the staff had not said anything at all about dangerousness. And petitioner could not possibly have relied on Calhoun's opinion, as he claimed, because Calhoun did not even examine respondent until February 22, 1964, 44 days *after* the January 9, 1964 staff conference. H at 520-25, 530-32; Defendant's Exhibit No. 1 at 5. When petitioner reported the results of this staff conference to a state legislator interested in respondent's case, he again falsely claimed that it was the "unanimous" opinion of the staff that respondent "even may present some degree of danger to others." A at 214-15; H at 526-27. Petitioner also claimed that

5. If released, respondent would have been able to provide for his basic needs in the community: he did not need custodial care.

There was evidence from which the jury could have concluded that respondent was not so mentally ill as to require long-term involuntary confinement for his own welfare.

Dr. Fox testified that he found no evidence in the record to justify a diagnosis of schizophrenia or, in any event, to justify 15 years of confinement. A at 30; T 11/21/72 at 68-69, 106. He noted that respondent "was always finding jobs and was not a welfare case." A at 13; T 11/21/72 at 80. As Dr. Fox pointed out (A at 5; T 11/21/72 at 70-71):

> "There was nothing in his past history that showed that he wasn't a generally self-sustaining if frequently moving individual. Everything would point to the fact that here was an individual who had made it pretty well, who was responsible, who did have regard for his fellow human beings, and right off you look at this guy as somebody to get out of the hospital very soon, and one of the ways you would do that is by giving him as much freedom as possible as soon as possible."

Respondent's case, according to Dr. Fox, "wasn't that complicated a case." A at 16; T 11/21/72 at 83. In fact, "given the positive steps that could have been taken to treat Mr. Donaldson *even in an institution with limited resources*" it was Dr. Fox's opinion that it would have been necessary to confine him for no more than "two or three months," and "it probably would take less. It

letter was based in part on Calhoun's examination (A at 133; T 11/27/72 at 89), even though the letter was dated January 9, 1964, 44 days prior to Calhoun's examination.

should take less." A at 16-17; T 11/21/72 at 82-83. (Emphasis added.)[14]

Dr. Raymond D. Fowler, Chairman of the Department of Psychology at the University of Alabama (see note 11, *supra*), reviewed respondent's record, including all of respondent's psychological tests and the underlying raw data. He found no evidence that respondent had been schizophrenic (A at 61; T 11/22/72 at 392), and testified further that "at least 10 percent and probably more" of all "college students would have profiles as deviant or more deviant than" respondent's on the Minnesota Multiphasic Personality Index ("MMPI") (A at 74; T 11/22/72 at 403); that the raw data from these examinations showed that respondent's behavior was "quite well organized" (A at 73; T 11/22/72 at 402); and that he "doubted" that he would ever have recommended hospitalization for respondent. A at 72; T 11/22/72 at 401.

Petitioner's co-defendant John Gumanis conceded that respondent "probably could have earned a living if he had gone out of the hospital." A at 113; T 11/27/72 at 37. In fact, after his discharge respondent took a bus to Syracuse, New York, where, within a week, he found a steady and responsible hotel job which he had held over a year by the time of trial. T 11/21/72 at 170-172. His employer, John Colozzi, testified that respondent "caught on very fast and very well," "conducted himself as a normal individual," showed up on time and never missed a day of work, ran the entire hotel from midnight until 8:00 a.m., balanced the accounts, received all monies, and "handled the job very well." T 11/21/72 at 159-168.

[14] Petitioner knew, as Dr. Fox pointed out on cross-examination, that when respondent had been hospitalized 14 years earlier at Marcy State Hospital, with the same diagnosis petitioner later applied to him, he had been released after only three months and had managed to care for himself and avoid re-hospitalization for the next 14 years. T 11/21/72 at 97-98; H at 1, 8, 30, 35, 64, 72.

There was additional evidence from which the jury could have concluded that respondent's mental condition did not change or improve during his fifteen-year confinement, indicating that he would have been equally capable of finding and holding a job throughout the period of his confinement. For example, Dr. Fowler testified that between 1958 and 1971, respondent's "test results were very much the same. . . . Specifically, the one that you can point to as a sort of an objective measure, the MMPI, looks about the same fourteen years later as it did previously." A at 62; T 11/22/72 at 393. Julian Davis, the hospital's psychologist, agreed with that conclusion, and agreed that respondent's mental condition, as reflected in the MMPI, was "basically the same" the day he was discharged as it was in 1958. A at 59; T 11/22/72 at 371-72. John Lembcke testified that respondent was, at the time of trial, "the same man that [he] knew back in college." T 11/21/72 at 134. And even petitioner agreed that there was no material change in respondent's mental condition during his hospitalization. T 11/27/72 at 81.[15]

From this evidence the jury could have concluded there was no reasonable basis to believe that, if released, respondent would not have been able to provide for his basic needs in the community.

[15] In addition, the jury was aware that, while confined, respondent wrote and published an article in a law review. T 11/22/72 at 277. The article, *Right to Treatment Inside Out*, 57 Georgetown L. J. 194 (1969), was offered but not received in evidence. The author of the article is identified only as a mental patient bearing hospital identification number A-25738, which was respondent's number at Florida State Hospital. A at 189.

6. Petitioner knew he had the authority, as attending physician and later as superintendent, to release respondent.

Petitioner concedes that he had the authority to grant respondent a "permanent" and unconditional release from the hospital if respondent had recovered. And there was evidence, see note 17 *infra*, that even if respondent had been mentally ill at the time of commitment, which respondent did not and does not concede, shortly thereafter the hospital staff recognized that respondent's alleged mental illness was "in remission," which would have allowed his release. Petitioner now claims, however, that he did not have the authority to release respondent on a "temporary" or conditional basis unless respondent had "recovered." Petr. Brief at 57; *see also*, at 4, 52, and 56. This claim was not advanced at trial, finds *no* support in the evidence, and is directly contrary to the evidence. In this section, respondent will show that even if petitioner thought respondent was still mentally ill, petitioner had the authority, both as attending physician and later as superintendent, to restore respondent to liberty by granting him a "temporary" or conditional release.

Throughout respondent's confinement there were two basic procedures for terminating hospitalization. The first, a "competency discharge," ordinarily required a "staff conference" and a determination by a majority of the medical staff that the patient had regained competency.[16] But the second procedure, which was variously described as a "trial visit," a "home visit," a "furlough" or an "out of state discharge," did *not* require a staff conference, and was *not* conditioned upon restoration of

[16] In fact, however, a staff conference was not essential, and, when a new superintendent replaced petitioner, in 1971, respondent was finally given a competency discharge without appearing before a staff conference. T 11/27/72 at 178-181; T 11/22/72 at 239.

competence. Every witness who testified confirmed these points.

Petitioner, for example, testified that "the typical trial visit was handled by the patient's attending psychiatrist." A at 163; T 11/28/72 at 22. A defense witness, Dr. W. D. Rogers, Director of the Florida Division of Mental Health, and Superintendent of Florida State Hospital from 1950 to 1963 (A at 148; T 11/27/72 at 144, 148), testified as follows (A at 150-51; T 11/27/72 at 150-51):

> "A. We have *always had in effect there a procedure for releasing a patient on a trial visit.* It was known as a trial visit. *This was a decision made by the treating psychiatrist.*
>
> "He can release the patient to *family, guardian or to some responsible person* who would assure the hospital of adequate care and supervision of the patient." (Emphasis added.)

Petitioner's co-defendant John Gumanis conceded that for "ordinary cases" the attending psychiatrist could release a patient on "furlough" without consulting the superintendent (A at 101-02; T 11/27/72 at 6), and confirmed that a patient could be released on furlough even if he had *not* regained competency and was still considered mentally ill. A at 100; T 11/27/72 at 5. Defendants' Exhibit No. 4, p. 10 (A at 242), the deposition of Dr. Rich, former Clinical Director at Florida State Hospital, confirms that even an "incompetent" patient "*could be released on trial visit strictly by his own doctor, without any other doctor being involved.*" (Emphasis added.)

In addition, petitioner's brief mischaracterizes trial visits as solely "temporary" in nature. Petr. Brief at 57. As Dr. Rogers testified, trial visits could be for a full year, at the end of which the released patient would be "discharged." A at 150-51. Co-defendant Gumanis

concurred. A at 100; T 11/27/72 at 5. Dr. Rich testified that Florida State Hospital did not even keep track of patients released on trial visit. Defendant's Exhibit No. 4 at 11. Finally, the Hospital Regulations (at 60) provided:

> "Some patients who suffer from recurring mental illness or who cannot be declared completely mentally competent are released from the Hospital in the care of a responsible relative or other individual for a period of twelve months.
>
> * * * *
>
> "Those patients who have been absent from the Hospital for twelve consecutive months are automatically discharged and removed from the Hospital census."

In summary, if petitioner had wanted to release respondent, he had the authority to do so.

7. Petitioner did not take the steps he could and should have taken to release respondent, and instead, intentionally blocked respondent's attempts to be released to the supervision of responsible friends and organizations.

Dr. Fox testified that the hospital record showed "for the first few years . . . almost an indifference to discharge. It was almost as if this was not one of the hospital's goals." [17] A at 6-7; T 11/21/72 at 72-73. Later,

[17] Petitioner's co-defendant Gumanis testified that if respondent's alleged illness had been "in remission," he would have been released from the hospital. T 11/27/72 at 21. But despite the fact that the first progress note in respondent's record stated that he "appears to be in remission" (A at 199), petitioner, then respondent's attending physician, made no effort to release him. Instead, petitioner responded to a contemporaneous inquiry from Travelers Aid in Philadelphia by saying that respondent would need "further hospitalization." H at 193. In March of 1957, while "in remission," respondent asked petitioner, then his attending physician, to initiate a staff conference at which other physicians could consider his release. H at 168-69. Petitioner refused.

however, Dr. Fox found "more than just indifference," he found "actual resistance to the discharge of Mr. Donaldson." *Id.* The resistance Dr. Fox described was most pronounced when outsiders attempted to have respondent released to their care.

Release to Helping Hands, Inc. On June 6, 1963, the president of Helping Hands, Inc., a halfway house for former mental patients, wrote a letter to Florida State Hospital which read, in part, as follows (A at 207; H at 494):

> "We are interested in the possibility of signing out your patient, Kenneth Donaldson, and taking him as a resident at our halfway house at 3800 Columbus Avenue, Minneapolis. A maximum of six people live here, including our house mother, and myself, as president. At this time we have a room for Kenneth, who has interested us very much through his letters."

Enclosed was a brochure describing Helping Hands (H at 492) and a letter from the Minneapolis Clinic of Psychiatry and Neurology (A at 206(c)-206(c)(i)) (described by petitioner's co-defendant as a "good clinic" (T 11/22/72 at 483)), which praised Helping Hands and expressed the opinion that "it would be impossible in any of our State Hospitals for a patient to receive the type of attention and care" provided at Helping Hands. H at 493. Five days after that letter was received, petitioner replied that respondent could not be released to anyone other than his parents. A at 208; H at 495. The letter stated that respondent was then 55 years old. Petitioner therefore knew that respondent's parents were elderly, and he also knew they were quite infirm.[18]

[18] Almost every letter received from respondent's parents from mid-1959 on spoke of their failing health and of the incapacities of their age. H at 263, 274, 286-87, 290-91, 355, 452-53, 455-56, and 461. In February of 1960 they had written quite straight-

Defendant Gumanis admitted that "Helping Hands could have helped Mr. Donaldson." T 11/22/72 at 483. Gumanis testified that he "was of the opinion the patient would be helped from Helping Hands. I still think the patient could have been helped by Helping Hands." A at 108; T 11/27/72 at 14. He then testified that "the decision [to reject] was made by Dr. O'Connor, the Superintendent." A at 108-09; T 11/27/72 at 14. Earlier, Gumanis had testified that the "final decision" would have "laid with Dr. O'Connor." T 11/22/72 at 484. Petitioner, for his part, though admitting that he knew "nothing" about Helping Hands when he signed the rejection letter, claimed that "apparently," the decision to reject the Helping Hands offer was based on "the opinion of the attending physician" who was, at that time, co-defendant Gumanis. A at 134; T 11/27/72 at 90. The initials below the signature block indicate that they jointly drafted the rejection letter.[19]

Release to John Lembcke. On July 3, 1964, Mr. John H. Lembcke wrote petitioner to ask if there were "any conditions" under which respondent, whom he described as "a friend of mine," could be released to Lembcke's custody. A at 217; H at 540. Lembcke was not an irresponsible, intermeddling do-gooder. He was a married man, with three children, and, as his letterhead indicated,

forwardly that they thought they were "too old to be responsible" for respondent. H at 271.

[19] Moreover, the circumstances surrounding this rejection showed bad faith. Although the rejection letter claimed that respondent's parents were "legally responsible for him" (A at 208; H at 495-97), petitioner answered a contemporaneous letter from respondent's parents without even informing them of the Helping Hands offer. A at 209-11; H at 496-98. Gumanis placed responsibility for that omission on petitioner. A at 112; T 11/27/72 at 16-17. And elsewhere, petitioner expressly acknowledged that respondent could be released to someone other than his parents (A at 216(a); H at 539), despite his assertion to the contrary in the Helping Hands rejection letter.

was responsibly employed as a Certified Public Accountant. T 11/21/72 at 119. More importantly, he was probably respondent's oldest friend, and was known and respected by respondent's family, who had described him to petitioner as respondent's "pal and good friend." T 11/21/72 at 120, 136; H at 224-26. Nevertheless, the same day petitioner received Lembcke's request, without even mentioning the request to respondent, petitioner addressed to Gumanis a handwritten note which said: "Recommend turn it down." A at 216; H at 538. The note began by saying "This man himself [Lembcke] must not be well to want to get involved with someone like this patient . . . ." A at 216; H at 538. In his deposition submitted at trial, petitioner tried to minimize the importance of that note as "an off-hand remark made by one doctor to another doctor regarding a situation that had arisen calling for a decision to be made." A at 135-36; T 11/27/72 at 91. But it was that "off-hand remark" which caused Gumanis to draft a letter to Lembcke (A at 218), rejecting Lembcke's request. A at 85-86; T 11/22/72 at 457-58. Gumanis noted in respondent's record, under date of July 7, 1964: "A Mr. John Lembcke, a public accountant, wishes to sponsor him in New York, however Dr. O'Connor does not agree with this plan." A at 201(a); H at 67.

On November 24, 1964 petitioner received another letter from Lembcke asking to have respondent released to his care. A at 219; H at 553. The next day, petitioner instructed Gumanis to "please answer in negative." A at 220; H at 554. As reasons for this summary denial, petitioner listed a need for parental consent, the supposed unlikelihood of respondent's staying with Lembcke, and petitioner's lack of knowledge about Lembcke. *Id.* But petitioner never requested parental consent, and as will be seen below, the parents readily consented to releasing respondent to Lembcke's care when Lembcke subsequently requested consent. As in-

structed, Gumanis drafted another letter to Lembcke denying his request. A at 221; H at 555. He did not mention any of the reasons that petitioner had given, even though in his letter Lembcke had offered to "submit any information" that was needed. A at 219; H at 553. Gumanis testified that petitioner "told me to put it in a negative manner and that is exactly what I done." A at 93; T 11/22/72 at 468.

In May of 1966, Lembcke traveled from New York to Florida State Hospital, visited respondent, and talked with petitioner and Gumanis about respondent's release. T 11/21/72 at 125. Gumanis conceded that he "didn't see anything wrong with Mr. Lembcke" and "as far as I could tell," Lembcke "would have been adequate to manage Mr. Donaldson." A at 95. Lembcke also visited respondent's parents who, on May 14, 1966, jointly executed a notarized letter addressed to petitioner, in which they expressly gave "permission that our son, Kenneth Donaldson, be turned over to the care and supervision of John H. Lembcke." A at 228; Plaintiff's Exhibit No. 4. At that point, however, discouraged by his conversations earlier that week with petitioner and Gumanis, at which time they had refused to release respondent to his care (T 11/21/72 at 125, 138, 141), and aware that "Kenneth was exploring other ways to attain his release" (A at 227(a); H at 770), Lembcke did not pursue the matter further.

Finally, in 1968, when respondent was transferred to Dr. Hanenson's department, Hanenson called Lembcke long distance to arrange for respondent's release. T 11/21/72 at 125. He also scheduled respondent for a staff conference, which was not attended by petitioner. On March 21, the staff unanimously recommended that respondent be released "on trial visit or out of state discharge." A at 197; H at 47. There was some delay in working out the arrangements for release to Lembcke,

and in June of 1968 respondent wrote a letter to W. D. Rogers, by then Director of Mental Health for the State of Florida, asking if anything could be done to expedite the process. A at 225-26; H at 752. Dr. Rogers forwarded respondent's letter to petitioner, who apparently had no knowledge at that time of the staff plan to release respondent. Petitioner forwarded respondent's letter to Dr. Hanenson and asked Hanenson to give petitioner information about the contemplated release. Dr. Hanenson responded a few days later in a memorandum which explained and supported the staff plan for release to Lembcke. A at 224-224(a); H at 749. Across the bottom of that memorandum petitioner wrote, in his own hand, "the record will show, I believe, we have been through this before and decided Mr. Lembcke would not properly supervise the patient." H at 749; *see also*, A at 138; T 11/27/72 at 94.[20] When asked to do so, petitioner could not locate that decision in the hospital record (A at 139; T 11/27/72 at 94), and in fact, other than petitioner's notes to Gumanis, no such decision appears at any place in the record.

The staff plan to release respondent was thereupon abandoned and Lembcke was advised that respondent would not be released "at this time." A at 229; H at 775. That rejection letter imposed additional requirements, including "a more recent" parental release. As Lembcke put it, "after requirements were met, requirements were increased." T 11/21/72 at 132. From this evidence the jury could have found that the staff plan to release respondent was abandoned because of petitioner's discovery and disapproval of the plan. As the Court of Appeals noted, "the jury would have been justified in concluding that the frustration of Lembcke's effort to secure Donaldson's release in 1968 was en-

[20] The handwritten note was omitted when petitioner re-typed the memorandum for the Appendix (A at 224-224(a)), but appears clearly in the hospital record copy. H at 749.

tirely or primarily the result of O'Connor's bad faith intervention . . . ." 493 F.2d at 517.[21]

* * *

[21] There is further evidence in the record from which the jury could have concluded that petitioner willfully and maliciously blocked respondent's efforts to be released to the supervision of responsible friends and organizations because petitioner felt such efforts to be an attack upon his personal authority. During his confinement, respondent wrote letters to the Governor, to the state mental health commissioner, to state and federal legislators and judges, to lawyers, and to others, in nearly all of which respondent criticized conditions at petitioner's institution, and questioned the legality of his confinement. Those letters elicited personal replies from United States Senators Richard Russell and Stuart Symington, from George Meany, Governor Frank Lausche of Ohio, the editors of Time Magazine (who published one of respondent's letters) and others. T 11/21/72 at 203-04; Plaintiff's Exhibit No. 10. His letters also elicited inquiries from various officials, which caused petitioner to complain of "the constant burden of extra work [respondent] has placed upon the staff as a result of his baseless allegations . . . ." H at 681.

In fact, respondent's letters were not "baseless allegations" and were in part responsible for a legislative investigation of conditions at Florida State Hospital. On May 1, 1961, S. Chesterfield Smith, then Chairman of the Committee on State Institutions, and subsequently President of the American Bar Association, submitted a report that was highly critical of the hospital, noting that "the wards are maintained more as detention wards for inmates than they are as hospital wards for the sick." *Final Report of the General Findings of the Committee on State Institutions Relating to the Conditions at Florida State Hospital and the Alleged Mistreatment of Patients*, at 3.

Petitioner's own letters were preoccupied with, and constantly referred to, respondent's letters to public officials. *See*, for example, H at 232, 234, 239, 259, 382-83, 407-08, 483, 515-17, and 670-81. On at least one occasion, petitioner appeared to have initiated a search of respondent's hospital record to discover whether respondent had corresponded with a particular state legislator. *See*, H at 506. Thus, the jury could have concluded that petitioner was annoyed by respondent's challenge to his authority, and determined to continue respondent's confinement as punishment.

As the Court of Appeals noted, "there were suggestions in the record that Dr. O'Connor's conduct . . . was influenced by his knowledge of Donaldson's history of writing letters to the press and to outside officials." 493 F.2d at 517.

In summary, there was sufficient evidence for the jury to conclude that respondent was committed for the purpose of treatment; that petitioner knew respondent received no treatment; that petitioner knew respondent was not dangerous to himself or to others and would have been able to provide for his basic needs in the community; that petitioner knew he had the authority to release respondent but instead intentionally blocked his efforts to be released, and acted not only in bad faith, but also with malicious, wanton and oppressive disregard for respondent's rights and welfare. As the Court of Appeals ruled, "there was ample evidence" to support the jury's verdict. 493 F.2d at 513.

SUMMARY OF ARGUMENT

I.

Respondent was involuntarily committed to Florida State Hospital under non-criminal standards and procedures. Under the commitment order, the statutes then in effect, and the Hospital Regulations, respondent was confined expressly for the purpose of receiving treatment for his alleged mental illness. Petitioner knew that respondent was not receiving *any* treatment, and that he was receiving only the custodial care he would have received in a prison. Petitioner knew that respondent was not dangerous to himself or to others, and that respondent was capable of providing for his basic needs in the community. Petitioner had the authority to release respondent from the hospital, but instead allowed his confinement to continue for nearly fifteen years.

Involuntary commitment involves a "massive curtailment of liberty," *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), and affects "fundamental rights." *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966). Avoiding such massive curtailment of fundamental rights is an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970).

The due process clause of the Fourteenth Amendment requires that the "nature" of confinement bear a reasonable relation to the "purpose" for confinement. *Jackson* v. *Indiana*, 406 U.S. 715, 738 (1972). Where, as here, the stated purpose for confinement is the provision of treatment, it follows under *Jackson* that confinement without treatment would not bear a reasonable relation to the purpose for confinement. Accordingly, in the circumstances of this case, respondent had a right under the due process clause of the Fourteenth Amendment to treatment or else to release.

II.

In order to award even compensatory damages, the jury had to find (a) that petitioner knew respondent was not dangerous; (b) that petitioner knew respondent received only custodial care; *and* (c) that petitioner did not reasonably and in good faith believe that respondent's continued confinement was lawful. Before awarding punitive damages, the jury had to find, in addition, that petitioner's acts constituted "extraordinary misconduct" and were "malicious, wanton or oppressive."

Petitioner did not and does not challenge the propriety of the instructions regarding the award of compensatory or punitive damages, and the instructions were in accord with applicable law. Because the jury found that petitioner *knew* his acts were unlawful, there is no issue of "retroactivity" in this case. There is, therefore, no issue of law regarding damages before this Court. The only issue regarding damages is the sufficiency of the evidence to support the jury's verdict. The Court of Appeals found "ample evidence" to support the verdict, and petitioner has suggested no reason why this Court should review, much less reverse, the jury's determination that petitioner acted in bad faith, with malicious, wanton and oppressive disregard for respondent's rights and welfare.

ARGUMENT

I. UNDER THE DUE PROCESS CLAUSE, RESPONDENT, WHO WAS INVOLUNTARILY CONFINED AS MENTALLY ILL UNDER NON-CRIMINAL STANDARDS AND PROCEDURES FOR FIFTEEN YEARS AND WHO WAS DANGEROUS NEITHER TO HIMSELF NOR TO OTHERS, HAD A RIGHT TO BE RESTORED TO LIBERTY EITHER BY TREATMENT OF ELSE BY RELEASE

As this Court observed in *Jackson* v. *Indiana*, 406 U.S. 715, 737-38 (1972):

> "The States have traditionally exercised broad power to commit persons found to be mentally ill. . . . Considering the number of persons affected, it is perhaps remarkable that the substantive constitutional limitations on this power have not been more frequently litigated." (Citations omitted.)

The central question in this case involves just such a limitation: did respondent, a mental patient who was involuntarily confined for 15 years in Florida State Hospital and who was dangerous neither to himself nor to others, have a substantive constitutional right to be restored to liberty either by treatment or else by release. This question, as it arises here, is a narrow but important one.

It is important because those mentally ill persons subjected to the states' involuntary, civil commitment processes, are one of the most vulnerable segments of society—usually destitute, often without families, and generally powerless to resist the arbitrary exercise of state authority affecting their most basic personal liberties.[22] The mentally ill are particularly vulnerable *after*

---

[22] *See generally*, American Bar Foundation, The Mentally Disabled and the Law 1-14 (S. Brakel and R. Rock, eds.) (rev. ed. 1971) (hereinafter "ABF Study"); D. Rothman, Discovery of the

they have been involuntarily hospitalzed by court order, since, historically, both case and statutory law have focused primarily on commitment procedures rather than on post-confinement rights.[23] To safeguard the constitutional rights of mental patients courts must scrutinize the conditions of involuntary confinement.[24] The most

---

Asylum (1971); R. Rock, M. Jacobson and J. Janopaul, Hospitalization and Discharge of the Mentally Ill (1968); E. Goffman, Asylums (1961); Joint Commission on Mental Illness and Health, Action for Mental Health (1961); A. Deutsch, The Mentally Ill in America (2d ed. 1949).

See also, Hearings on the Constitutional Rights of the Mentally Ill Before the Subcomm. on Constit. Rights of the Senate Comm. on the Judiciary, 87th Cong., 1st Sess., 1 (1961) (hereinafter, the "1961 Hearings"); *Hearings on The Constitutional Rights of the Mentally Ill Before the Subcomm. on Consit. Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st and 2d Sess. (1969-70) (hereinafter, "1970 Hearings").

[23] "Recognizing that commitment of the mentally ill is a serious deprivation of liberty, the law has encouraged the use of procedural safeguards . . . for commitment proceedings. However, there has been little corresponding consideration of an inmate's rights after commitment." Note, *The Nascent Right to Treatment*, 53 Va. L. Rev. 1134, 1135 (1967) (hereinafter, "Virginia Note"), citing A. Deutsch, note 22, *supra* and M. Guttmacher & H. Weihoffen, Psychiatry and the Law (1952). *See also*, ABF Study, *supra*, note 22, at 171 ("Statutes by and large do not adequately protect the rights of patients who have been hospitalized."); 1961 Hearings, *supra*, note 22, at 1 (remarks of Sen. Ervin: "the constitutional rights of hundreds of thousands of patients" after they are confined under governmental control "are of much greater significance" than the rights which attach before confinement during "hospitalization procedures."); Mental Health Law Project and Practicing Law Institute, Legal Rights of the Mentally Handicapped 275 (B. Ennis & P. Friedman eds. 1973).

[24] Conditions in large state mental hospitals have historically been inadequate at best. *Jackson* v. *Indiana*, 406 U.S. 715, 734-35, n.17 (1972). There "are substantial doubts about whether the rationale for pretrial commitment—that care and treatment will aid the accused in attaining competency—is empirically valid given the state of most of our mental institutions." *Id. See also*, ABF Study, *supra*, note 22, at 417-18. *See generally*, A. Deutsch, *supra*, note 22; A. Deutsch, The Shame of the States (1948); Joint Commission on Mental Illness and Health, *supra*, note 22; Solomon, *The*

critical of the post-confinement rights—the right to be restored to liberty either by treatment or else by release—has been recognized and endorsed by medical experts,[25] by legal commentators,[26] and by the United

---

American Psychiatric Association in Relation to American Psychiatry, 115 Am. J. Psychiatry 1 (1958); Joint Information Service of the American Psychiatric Association and the National Association for Mental Health, Fifteen Indices: An Aid in Reviewing State and Local Mental Health Programs 6 (1966); American Psychiatric Association Task Force on the Right to Care and Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded 1 (4th Draft, Oct. 1974).

[25] *See, e.g., amici curiae* briefs in support of the constitutional right to treatment or release filed in the instant case by American Psychological Association, American Psychiatric Association, American Orthopsychiatric Association and National Association for Mental Health. *See also*, American Psychiatric Association Task Force on the Right to Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded 1 (4th Draft, Oct. 1974) ("The American Psychiatric Association, whose membership has always *implicitly* recognized and worked to implement the right to adequate care and treatment, now joins and endorses efforts towards this goal by stating its *explicit* support of this right.") (Emphasis in original.)

[26] The constitutional right to treatment or release for involuntarily committed mental patients has "received an unusual amount of scholarly discussion and support." *Donaldson* v. *O'Connor*, 493 F.2d 507 (5th Cir. 1974). The first articulation of the right is found in Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960). In the last 15 years more than 30 law review articles have been published on the subject, virtually all of them supporting a constitutional right to treatment or release for the involuntarily confined. *See, e.g.*, Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190 (1974) (hereinafter "*Developments—Civil Commitment*"); Note, *Rights of the Mentally Ill During Incarceration—the Developing Law*, 25 U. Fla. L. Rev. 494 (1973); Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282 (1973) (hereinafter "*Wyatt* Comment"); Robitscher, *Right to Psychiatric Treatment: A Social-Legal Approach to the Plight of the State Hospital Patient*, 18 Vill. L. Rev. 11 (1972); Murdock, *Civil Rights of the Mentally Retarded: Some Critical Issues*, 48 Notre Dame Lawyer 951 (1972); Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Con-*

States.[27] Most importantly, there exists "an enormous range of precedent" supporting such a right, *Donaldson* v. *O'Connor*, 493 F.2d 507, 519-20 (5th Cir. 1974.) [28]

stitutional Imperatives, 70 Mich. L. Rev. 1108 (1972); Goodman, *Right to Treatment: The Responsibility of the Courts*, 57 Georgetown L. J. 680 (1969); Katz, *The Right to Treatment—An Enchanting Legal Fiction*, 36 U. Chi. L. Rev. 755 (1969); Virginia Note, *supra*, note 23; Note, *Civil Restraint, Mental Illness and the Right to Treatment*, 77 Yale L. J. 87 (1967); Drake, *Enforcing The Right To Treatment*, 10 Am. Crim. L. Rev. 587 (1972).

[27] The United States has participated in many of the important right to treatment cases. In *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974), the United States stated that its interest as *amicus curiae* was to attack the "widespread and severe deprivation of the constitutional rights of citizens" who are civilly committed and urged the court to recognize that involuntarily confined mental patients "have a constitutional right to receive such treatment . . . as will give them a realistic opportunity to be cured or to improve their condition." Brief of *Amicus Curiae* United States, at 9. Early in 1974, the Justice Department filed suit in the name of the United States against Rosewood State Hospital in Maryland, alleging, *inter alia*, that the state had deprived civilly committed patients of their constitutional right to treatment. *United States* v. *Solomon, et al.*, Civ. Act. No. 74-181 (D. Md., filed Feb. 21, 1974). The United States has also participated as *amicus* with the rights of a party in another suit seeking a right to treatment or habilitation for the mentally retarded. *New York Ass'n for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973).

[28] The constitutional right to treatment or release for the mentally ill and the mentally retarded has been recognized by both federal and state courts. *See, e.g., Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971) and 344 F. Supp. 387, 390 (M.D. Ala. 1972), *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974) (class actions on behalf of the mentally ill and the mentally retarded); *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) (class action involving the mentally retarded); *Davis, et al.* v. *Watkins, et al.*, No. C 73-205, slip opinion at 1-2 (N.D. Ohio, Sept. 1974) (interim order) (class action on behalf of the mentally ill); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973); *Kesselbrenner* v. *Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973); *Renelli* v. *Dept. of Mental Hygiene*, 340 N.Y.S.2d 498, —— N.E.2d —— (1973).

There is also a widening body of precedent holding that there is a constitutional right to treatment for persons committed under "non-penal" statutes for the purpose of care and treatment: (a)

The right to be restored to liberty either by treatment or else by release is a right that has been recognized in many different factual contexts, each with varying legal issues and societal interests. But in order to resolve the issues raised by the facts and jury instructions of this case, this Court need not resolve issues that have been (or might be) raised by other, quite different "right to treatment" cases. Here, a harmless mental patient who was confined for the express purpose of treatment sought damages for the failure of state officials to release him when they knew he was not re-

juvenile delinquents, *Nelson* v. *Heyne*, 355 F. Supp. 451, 459 (N.D. Ind. 1972), *aff'd*, 491 F.2d 352, 360 (7th Cir. 1974), *cert. denied*, —— U.S. ——; *Inmates of Boys Training School* v. *Affleck*, 346 F. Supp. 1354, 1364 (D. R.I. 1972); *Morales* v. *Turman*, 364 F. Supp. 166, 175 (E.D. Tex. 1973); (b) *"persons in need of supervision," Martarella* v. *Kelley*, 349 F. Supp. 575, 585, 598-600 (S.D. N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973); *M* v. *M*, 336 N.Y.S.2d 304, 71 Misc.2d 396 (Fam. Ct. 1970); *In re J*, 316 N.Y.S.2d 356 (Fam. Ct. 1970); (c) *sexual offenders and defective delinquents*, *Stachulak* v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Davy* v. *Sullivan*, 354 F. Supp. 1320, 1328-1329 (M.D. Md. 1973) (three judge court); *Gomes* v. *Gaughn*, 471 F.2d 794, 800 (1st Cir. 1973); *Sas* v. *Maryland*, 334 F.2d 506 (4th Cir. 1964), *cert. denied*, 407 U.S. 355 (1972); *In re Maddox*, 351 Mich. 358, 88 N.W.2d 470 (1958); *Commonwealth* v. *Page*, 339 Mass. 313, 159 N.E.2d 82 (1959); *Director of Patuxent Institution* v. *Daniels*, 243 Md. 16, 221 A.2d 397 (1966); *Silvers* v. *People*, 22 Mich. App. 1, 176 N.W.2d 702 (1970); and (d) *persons incompetent to stand trial*, *United States* v. *Walker*, 335 F. Supp. 705, 708 (N.D. Cal. 1971); *United States* v. *Pardue*, 354 F. Supp. 1377, 1382 (D. Conn. 1973); *Nason* v. *Superintendent of Bridgewater State Hospital*, 253 Mass. 604, 612-613, 233 N.E.2d 908, 913-14 (1968); *Maatallah* v. *Warden, Nevada State Prison*, 86 Nev. 430, 420 P.2d 122 (1970)).

The right to treatment was rejected by the District Court in *Burnham* v. *Department of Public Health*, 349 F. Supp. 1335 (N.D. Ga. 1972), *reversed and remanded*, No. 72-3110 (5th Cir. Nov. 8, 1974). In *N.Y. State Ass'n for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752, 762 (E.D.N.Y. 1973), the District Court did not recognize the right to treatment when deciding whether to grant a preliminary injunction but subsequently reserved decision on the issue pending presentation of evidence and further briefing. No. 72 Civ. 356, 357, Order of May 23, 1974, at 2.

ceiving treatment. Accordingly, in order to affirm the holding of the Court of Appeals, this Court need *not* decide:

1. Whether an involuntarily confined mental patient who is dangerous, either to self or to others, has a right to be treated or to be released;[29]
2. Whether civil commitment of the mentally ill for any purpose other than treatment is constitutionally permissible;
3. Whether the provision of treatment can itself justify the indeterminate or long-term confinement of mentally ill persons who are dangerous neither to self nor to others;
4. Whether courts can determine if the level of treatment received is "reasonable," in a constitutional sense, when, in contrast to this case, a patient receives more than the custodial care available in a prison;

[29] As will be discussed at pp. 58-59, *infra*, the Court of Appeals rested its decision on alternative holdings. The narrower one, which applies to the mentally ill who are dangerous neither to self nor to others, controls respondent's case. But respondent respectfully submits that the Court of Appeals' alternative holding, which applies to all involuntarily confined mental patients, was equally valid, *see* note 61, *infra*.

In any event, it should be emphasized that vast numbers of patients involuntarily confined in large mental institutions are not dangerous to self or to others. *See generally*, *Wyatt* Comment, *supra*, note 26, at 1289, n.43 (citing studies indicating that approximately 90% of patients involuntarily confined are not sufficiently dangerous to themselves or to others to require hospitalization). A 1970 study by the National Institute of Mental Health of the patient population at Saint Elizabeths Hospital in the District of Columbia revealed that nearly 70% of the patients confined therein did not have behavior problems and consequently could be discharged or released to such facilities as foster homes or half-way houses. National Center for Mental Health Services, Training and Research of NIMH, NCM-SEH Patient Inventory (1970).

5. Whether courts can establish institution-wide standards for ensuring the provision of treatment that is "reasonable" in a constitutional sense?[30]

Moreover, the impact of affirmance on Florida's mental health system will be negligible since, within the past two years, Florida has substantially altered its civil commitment law and has provided both a statutory right to treatment and a cause of action in damages against state doctors who abridge that right.[31]

The narrow "right to treatment" issue posed by this case is contained in the instructions to the jury. The oral charge, which will be discussed in greater detail below, was as follows:

> "In order to prove his claim under the Civil Rights Act, the burden is upon the Plaintiff in this case to establish by a preponderance of the evidence in this case the following facts:
>
> That the Defendants confined Plaintiff against his will, *knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness.*
>
> Second, that the Defendants then and there acted under the color of state law.
>
> Third, that the Defendants' acts and conduct deprived the Plaintiff of his Federal Constitutional right not to be denied or deprived of his liberty without due process of law as that phrase is defined

[30] The instant case is, therefore, to be distinguished from *Wyatt* v. *Aderholt*, *supra*, note 28, and from *Burnham* v. *Department of Public Health*, *supra*, note 28. Both *Wyatt* and *Burnham*, upon which petitioner relies, were class actions seeking declaratory and injunctive relief and the establishment of constitutionally required minimum standards governing conditions in state mental hospitals for the involuntarily confined.

[31] *See* pp. 70-71, 84-85, and notes 79 and 99, *infra*.

and explained in these instructions, and fourth, that the Defendants' acts and conduct were the proximate cause of his injury and consequent damages that he suffered. . . .

You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a *constitutional right to receive such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.*

Now, *the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others.* Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that the Plaintiff was dangerous either to himself or others." A at 183, 186.[32] (Emphasis added.)

In this section, respondent will demonstrate that these instructions were a correct statement of the applicable constitutional law. Although this Court has infrequently considered the rights of involuntarily confined mental patients, its concern for their constitutional rights is not new. The Court of Appeals' acknowledgement of respondent's post-commitment right to restoration of liberty by treatment or else by release, in the circumstances of this case, was consistent with the sensitive admonition of this Court issued nearly a quarter of a century ago:

> "We fully recognize the *danger of a deprivation of due process* in proceedings dealing with persons charged with insanity . . . and the *special importance of maintaining the basic interests of liberty* in a class of cases where the law though 'fair on its face and impartial in appearance' may be open to *serious abuses in administration* and courts may be imposed upon if the *substantial rights* of the persons charged are not adequately safeguarded at *every stage* of the proceedings."

Minnesota ex rel. Pearson v. *Probate Court*, 309 U.S. 270, 276-77 (1940). (Emphasis added.)

[32] This oral charge given to the jury was discussed in slightly different form in chambers as Plaintiff's Proposed Instructions #34, #37, and #38.

A. Respondent's Involuntary Civil Commitment Abridged His Constitutionally Protected Liberty

Recognition of respondent's right to treatment or release begins with the elementary principle that the civil commitment of the mentally ill infringes constitutionally protected liberty. In 1957, respondent was judged mentally incompetent, and was involuntarily and *indefinitely* committed to the Florida State Hospital at Chattahoochee under non-criminal standards and procedures. Not only did this commitment expressly impose civil disabilities by statute,[33] but, by placing him under the total control of state hospital authorities, it abridged the most basic aspect of constitutional liberty—the right to be free from physical confinement. *Arnett* v. *Kennedy*, 94 S.Ct. 1633, 1646 (1974) (core meaning of constitutional liberty is "the elemental freedom from external restraint."). Moreover, respondent's lengthy confinement as mentally ill infringed his due process right to be free from unwar-

[33] Title 27 Florida Statutes § 394.22(10) (Laws 1945, Ch. 23157 § 3) (repealed July 1, 1972) provided that

> After a judgment adjudicating a person to be mentally incompetent is filed in the office of the county judge, such person shall be presumed to be incapable, for the duration of such incompetence, of managing his own affairs or of making any gift, contract, or any instrument in writing which is binding on him or his estate.

For a discussion of the civil disabilities expressly imposed by civil commitment statutes, *see generally*, ABF Study, *supra*, note 22 at 155-341; *Developments—Civil Commitment*, *supra*, note 26, at 1198-1200.

ranted stigma.[34] Further, long-term confinement in mental institutions which provide only custodial care, if that, often causes deterioration, not improvement, in patients' mental conditions, leading to additional deprivations of liberty.[35] Finally, involuntary confinement abridges other basic constitutional rights.[36]

---

[34] Stigmatization constitutes a deprivation of constitutionally protected liberty, *Board of Regents* v. *Roth*, 408 U.S. 564, 573 (1972). A "former mental patient may suffer from social opprobrium which attaches to treatment for mental illness and which may have more severe consequences than do . . . formally imposed disabilities. . . . The legal and social consequences of commitment constitute the stigma of mental illness, a stigma that could be as socially debilitating as that of a criminal conviction," *Developments—Civil Commitment*, *supra*, note 26, at 1200-01 (and cases cited therein). "Civil commitment involves stigmatizing the affected individuals, and the stigma attached, though in theory less severe than the stigma attached to criminal conviction, may in reality be as severe, *or more so*." *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520 (Emphasis added.)

[35] The deterioration of patients' intellectual, social and physical functioning *as a result* of custodial confinement in large understaffed and overcrowded mental hospitals has been widely recognized in the medical and social science literature. The popular name for this phenomenon of deterioration is "institutionalization." *See, e.g.*, E. Goffman, Asylums (1961); R. Barton, Institutional Neurosis (1966); Gruenberg, *The Social Breakdown Syndrone —Some Origins*, 123 Am. J. Psychiatry 12 (1967); I. Belknap, Human Problems of State Mental Hospitals (1956); M. Schwartz & Schwartz, Social Approaches to Mental Patient Care (1964); J. Wing & G. Brown, Institutionalization and Schizophrenia (1970). *See also* Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 Mich. L. Rev. 1108, 1126-29 (1972); 1961 Hearings, *supra*, note 22, at 18, 43-44, 124, 637.

One of respondent's expert witnesses, Dr. Walter Fox, testified that respondent's lack of deterioration showed that respondent was uniquely independent: ". . . Mr. Donaldson had . . . more . . . internal strength than most of the people that would find themselves in that sort of total institution for that period of time." A 6; T 11/21/72 at 71.

[36] Involuntary confinement severely limits the exercise of other constitutional rights such as the right to privacy and personal autonomy, *Roe* v. *Wade*, 410 U.S. 113 (1973); the right to asociation, *Shelton* v. *Tucker*, 364 U.S. 479 (1960); the right to travel, *Shapiro* v. *Thompson*, 394 U.S. 618 (1969); the "right to work for a living in the common occupations of the community", *Truax* v. *Raich*, 239 U.S. 33 (1915); and the right to movement, *Papachristou* v. *City of Jacksonville*, 405 U.S. 156 (1972).

This Court has recognized that involuntary confinement of persons on the ground of mental illness affects "fundamental rights", *Baxstrom* v. *Herold*, 383 U.S. 107, 113 (1966), and entails a "massive curtailment of liberty" in a constitutional sense, *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972). Avoiding such extreme restrictions on liberty is an interest of "transcending value," *In re Winship*, 397 U.S. 358, 364 (1970). As Judge Wisdom noted below:

> "*The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary.* Indeed, civil commitment, because it is for an indefinite term, may in some ways involve a more serious abridgement of personal freedom than imprisonment for commission of a crime usually does . . . . *Since civil commitment involves deprivations of liberty of the kind with which the due process clause is frequently concerned, that clause has the major role in regulating government actions in this area.*"

Donaldson v. *O'Connor*, *supra*, 493 F.2d at 520. (Emphasis added; citations omitted.) And, as Judge Tamm has stated, "There can no longer be any doubt that the nature of the interests involved when a person . . . [is] involuntarily committed . . . is 'one within the contemplation of the "liberty and property" language of the Fourteenth Amendment.'" *In re Ballay*, 482 F.2d 648, 655 (D.C. Cir. 1973), quoting *Morrissey* v. *Brewer*, 408 U.S. 471, 481 (1972).

Respondent, though he had committed no crime, was deprived of liberty for 175 months, or nearly 15 years.

That compares with an average time served for federal convicts of only 17.7 months.[37] Persons convicted of homicide or rape on federal property serve, on the average 80.1 and 38.4 months, respectively.[38] In short, the deprivation of physical liberty involved in this case was much longer than that which society ordinarily deems justified even for the most serious crimes.

B. The Stated Purpose of Respondent's Involuntary Confinement Was To Provide Him With Treatment for His Mental Illness in Order To Return Him to the Community

If liberties cognizable under the Due Process Clause have been abridged by state action, then there are two basic methods for challenging the validity of the abridgment. First, the aggrieved party may question whether the abridgement can be justified in terms of a permissible governmental goal. *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738; *Roe* v. *Wade*, 410 U.S. 113, 173 (1973) (Rehnquist, J., dissenting); *Vlandis* v. *Kline*, 412 U.S. 441 (1973); *Williamson* v. *Lee Optical Co.*, 348 U.S. 483, 491 (1955); *Nebbia* v. *New York*, 291 U.S. 502, 525 (1934); *Meyer* v. *Nebraska*, 262 U.S. 390, 399-400 (1923). *Cf. James* v. *Strange*, 407 U.S. 128 (1972); *Eisenstadt* v. *Baird*, 405 U.S. 438 (1972).[39] Second, the aggrieved party may refrain from litigating the permissibility of the stated purpose, and simply question whether there is a rational relationship between the stated purpose of

---

[37] Federal Bureau of Prisons, Statistical Reports, Fiscal Year 1973, Table C-2, at 97-98.

[38] Federal Bureau of Prisons, Statistical Reports, Fiscal Year 1973, Table C-2, at 97-98.

[39] *See generally* Tribe, *Foreward: Toward a Model of Roles in the Due Process of Life Law*, 86 Harv. L. Rev. 1, 17 (1973). Cf. Gunther, *Foreward: In Search of Evolving Doctrine on a Changing Court: A Model for Newer Equal Protection*, 86 Harv. L. Rev. 1, 17-20 (1972).

the abridgement and the means for effecting that purpose. *Nebbia* v. *New York*, *supra*; *Meyer* v. *Nebraska*, *supra*; *Vlandis* v. *Kline*, *supra*; *Jackson* v. *Indiana*, *supra*.

Only this second approach was employed by respondent. Specifically, respondent neither challenged nor conceded the constitutional permissibility of abridging his constitutional right to liberty for the purpose of treatment. Instead, respondent proved at trial that there was no rational relation between the stated purpose of his confinement—treatment for mental illness in order to restore him to liberty—and the actual nature of that confinement.

1. *As petitioner knew, the stated purpose of respondent's confinement was to provide treatment so that respondent would be returned to the community.*

As has been noted above, *see* pp. 3-5, *supra*, the statute authorizing respondent's civil commitment expressly stated that involuntary confinement was "for the purpose of care, custody *and treatment*." Title 27 Florida Statutes 394.09 (1941) (Laws 1877, Ch. 3036 § 1) (repealed July 1, 1972). (Emphasis added.) Moreover, the judicial order delivering respondent to the state hospital expressly stated that respondent was committed "to the Superintendent of Florida State Hospital, Chattahoochee, Florida, for care, maintenance *and treatment*." Plaintiff's Exhibit 13, "Order for Delivery of Mentally Incompetent." (Emphasis added.) Both the statutory provision and the order were clear on their face that respondent was to receive more than mere custodial care. Because the phrases "care, custody and treatment" and "care, maintenance and treatment" are conjunctive in form, it follows that treatment was a necessary purpose of respondent's confinement. Moreover, as has also

been noted, *see* p. 4, *supra*, this purpose is reflected in the By-Laws, Rules and Regulations of the Medical Staff of Florida State Hospital, which were promulgated by petitioner during respondent's confinement. Those by-laws expressly state that the Florida State Hospital was "established to provide a *treatment facility* for the mentally ill", and state further: "Our *primary objective* is to return the patients as useful citizens, to their own community, as soon as possible. The mental hospital should only be an intermediate step in the *treatment and rehabilitation* of the patient." *See* p. 4, *supra*. (Emphasis added.)[40]

Thus express statute, order and regulation made clear that respondent was confined for the purpose of treatment. Moreover, the jury could have found, as fact, that

[40] There is increasing recognition that restoring the liberty of the mentally ill by returning the mentally ill to a productive normal life as soon as possible and insofar as possible should be the overarching objective of all civil commitment. Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A. J. 1371, 1371 (1974): "The major trend in mental health . . . is de-institutionalization. . . . The hypothesis of this trend is rehabilitation rather than incarceration. . . . The major provisons of the legislation and case law governing the commitment, admission, hospitalization and discharge of the mentally ill and retarded speak to maximizing the patient's opportunities to stay out, to get out, and while in to get the most advantages with the minimum of suffering." *See also* 1961 Hearings, note 22, *supra*, at 224 (Remarks of Sen. Ervin: ". . . the primary object of commitment is to treat people and restore them to society as soon as it is determined that they have the capacity to readjust themselves."); ABF Study, supra, note 22, at 39 ("primary mission" of state mental hospitals is "treatment of mental illness."); American Psychiatric Association, Standards for Psychiatric Facilities 2 (1969) ("The primary functions of any psychiatric facility are to diagnose, to treat and to restore mentally disordered persons to an optimal level of functioning, and return to the community.").

It would, therefore, be more analytically correct for courts and commentators to say that "treatment" is not a "purpose", but rather a "means" of effecting the only constitutionally permissible purpose of civil commitment, namely, the restoration of a mentally ill person's liberty and his return to the community.

petitioner knew that respondent was confined for the purpose of providing treatment that would restore respondent to the community.[41]

2. *Custodial care of a mentally ill person who is neither dangerous to himself nor to others is not a constitutionally permissible purpose for involuntary confinement.*

Petitioner asserts here for the first time that custodial care, *without more*, is a permissible purpose for involuntary confinement of the harmless mentally ill. Petr. Brief at 41-42. In making this assertion, petitioner simply ignores the state statutes, judicial order and Hospital Regulations in effect during respondent's confinement. These indicate that, although custodial care was a necessary purpose of confinement, it was not a necessary *and* sufficient purpose under state law, *i.e.*, it could not, by itself, justify involuntary confinement. Moreover, petitioner did not argue that custodial care alone justified confinement of a non-dangerous mental patient nor did he proposed a jury instruction to that effect.[42] Accord-

[41] The *By-Laws, Rules and Regulations of the Medical Staff of Florida State Hospital* promulgated by petitioner were introduced into evidence as Plaintiff's Exhibit #2. Petitioner also conceded that the purpose of confining respondent was to ensure that respondent could "make [an] adjustment" outside the hospital. A 130; T 11/28/72 at 86.

[42] To the contrary, petitioner did not object to the first sentence of Plaintiff's Proposed Instruction No. 38, which provided, as revised in chambers by the trial judge, that "the purpose of involuntary hospitalization is treatment, and not mere custodial care or punishment if a patient is not a danger to himself or others." T 11/28/72 at 8-9. In a pre-trial brief, petitioner had objected to that instruction as a whole, but only because of the second sentence, which provided "Without such treatment there is no justification, from a constitutional stand-point, for continued confinement." Petitioner *agreed* that confinement of non-dangerous persons without treatment was not justified, but proposed to limit the means by which such unjustifiably confined patients could secure release to

ingly, this issue is not properly before this Court.[43]

If, however, this Court chooses to reach the issue, it should decide that, for a mentally ill person, who is dangerous neither to himself nor to others, the provision of mere custodial care, which a person would receive in a prison, cannot justify the massive deprivation of liberty involuntary confinement entails.

Historically, states have justified civil commitment of the mentally ill according to two broad *purposes*: rehabilitation of the mentally ill individual pursuant to the state's beneficent *parens patriae* power or protection of society from dangerous persons pursuant to the state's police power. *See generally*, Note, *Civil Commitment of the Mentally Ill: Theories & Procedures*, 70 Harv. L. Rev. 1288 (1966); Note, *The Nascent Right to Treatment*, 53 Va. L. Rev. 1134, 1138-39 (1967) (hereinafter "Virginia Note"); Comment, *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 Harv. L. Rev. 1190, 1207-1240 (1974) (hereinafter *"Developments—Civil Commitment"*).[44]

Under these broad *parens patriae* or police powers, states have traditionally sought involuntary commitment

"judicial process," thereby excusing petitioner from liability for failure or refusal to exercise his authority to effect an administrative release. 493 F.2d at 518-19, n.8.

[43] *See* note 92, *infra*.

[44] The state's *parens patriae* power, which originally lodged in the King and now resides in the legislature, *Hawaii* v. *Standard Oil Co.*, 405 U.S. 251, 257 (1972), is "inherent in the supreme power of every state." *Mormon Church* v. *United States*, 136 U.S. 1, 57 (1890). The core of the concept is that the state acts as "guardian" of citizens with disabilities. *Hawaii* v. *Standard Oil Co.*, *supra*, 405 U.S. at 257. The power serves as the basis for state laws which protect minors, establish guardianships, and provide for the involuntary commitment of the mentally ill. *See generally, Developments—Civil Commitment, supra*, note 26, at 1207-10 (nature and origins of power).

of the mentally ill according to one of three *standards*: when mental illness results in (a) danger to others; (b) danger to self; or (c) the need for treatment. *Jackson* v. *Indiana*, *supra*, 406 U.S. at 737, n.19; American Bar Foundation, The Mentally Disabled and the Law 37-49 (S. Brakel & R. Rock eds.) (rev. ed. 1971) (hereinafter, "ABF Study") (summarizing the laws of the states as of 1971); *Developments—Civil Commitment*, *supra*, at 1203-4 (summarizing the laws of the states as of 1974).[45]

When the state civilly commits or continues to confine a mentally ill individual who is dangerous neither to himself nor to others, it is acting pursuant to its *parens patriae* power and the purpose of exercising that power is to promote the interests of the individual. *Id.*, at 1222; ABF Study, *supra*, at 34-40.[46] In such circumstances, civil commitment cannot be justified as an exercise of the police power for the protection of society. Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A. J. 1371 (1974).[47]

[45] The precise relationships between the broad *parens patriae* or police power goals which *justify* commitment and the statutory criteria which *trigger* commitment are "seldom spelled out" by state legislatures. Virginia Note, *supra*, note 26, at 1138. And the absence of litigation focusing on the legality of commitment standards has "left the boundaries of the state's commitment power largely undefined," *Developments—Civil Commitment*, *supra*, note 26, at 1207; *Jackson* v. *Indiana*, *supra*, 406 U.S. at 737-38.

[46] *See also*, Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 Harv. L. Rev. 1288, 1289, n.11 (1966) ("Unless proceedings against a person have met the standards for a dangerousness commitment, a hospital should only consider *his best interests* in treating him.") (Emphasis added); Virginia Note, *supra*, note 23, at 1138-39 (police power commitments look to dangerousness and protection of society not to the best interests of the individual).

[47] In *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520-21, Judge Wisdom noted that it "is analytically useful to conceive of these grounds as falling into two categories, one consisting of 'police power' rationales for confinement, the other of '*parens patriae*'

Under the instructions in this case, respondent bore the burden of proving that there was and could have been no police power rationale for his confinement. The judge instructed the jury that "the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others," A. 186, and the instructions required respondent to prove that petitioner confined respondent "knowing that he was not . . . dangerous." Accordingly, under the instructions in this case, the right to treatment or release was limited to persons civilly confined exclusively under the *parens patriae* power,[48] not under the police power.[49]

---

rationales . . . [The] need for care or treatment [is] a '*parens patriae*' rationale."

[48] The court below expressly viewed the purpose of respondent's continued confinement as exclusively a *parens patriae* purpose, 493 F.2d at 521.

[49] There was ample evidence before the jury to support a finding of non-dangerousness, *see* pp. 14-18, *supra*. Under applicable principles of appellate review it would be inappropriate for this Court to evaluate the sufficiency of the evidence or to reach a different assessment of the facts. Petitioner attempts to establish here that respondent was dangerous to self or to others, Petr. Brief at 9, 18, and to argue this case as if respondent were. *Id.* at 18-19. But petitioner offers no principles and cites no precedent which would justify upsetting the jury's finding. This is not surprising since the great weight of authority is against petitioner.

In reviewing a jury verdict, the appellate court "takes that view of the evidence that is most favorable to the appellee, that it assumes all conflicts in the evidence were resolved in his favor, and that he must be given the benefit of all favorable inferences." 9 Wright and Miller, Federal Practice and Procedure § 2585 at 730 (1971). *See also* 5A J. Moore, Federal Practice ¶ 52.02 at 2611 (2d ed. 1974). This limited appellate review of a jury's factual determinations has been consistently employed by this Court. *See, e.g. Atlantic & Gulf Stevedores, Inc.* v. *Ellerman Lines, Ltd.*, 369 U.S. 355, 358-59 (1962). *See also, Southwestern Brewery & Ice. Co.* v. *Schmidt*, 266 U.S. 162, 169 (1912) (Holmes, J.: Whether "there was . . . credible evidence to sustain the verdict . . . was for the jury, not for this court."); *Eastman Kodak Co.*

The question raised here by petitioner for the first time, then, is whether a mentally ill but non-dangerous person can constitutionally be confined pursuant to the state's *parens patriae* power *solely* for the purpose of providing custodial care.

This Court has never directly ruled upon that question, but even in cases in which confinement can be justified, at least in part, under the police power, this Court has not hesitated to acknowledge that custodial confinement *without treatment* raises "substantial constitutional" questions. *McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 250 (1972). *See also, Murel* v. *Baltimore City Criminal Ct.*, 407 U.S. 355, 358 (1972); *In re Gault*, 387 U.S. 1, 22, n.30 (1967). Furthermore, this Court has strongly suggested, though never explicitly ruled, that even the provision of treatment may not be sufficient to justify the indeterminate or long-term confinement of a mentally ill person who is dangerous neither to self nor to others. *Greenwood* v. *United States*, 350 U.S. 366 (1956); *Jackson* v. *Indiana*, 406 U.S. 715 (1972); *Humphrey* v. *Cady*, 405 U.S. 504 (1972).[50] If, as *Greenwood*, *Jackson* and *Humphrey*

---

v. *Southern Photo Materials Co.*, 273 U.S. 359, 375 (1927); *Lumberman's Mutual Casualty Co.* v. *Elbert*, 348 U.S. 48, 53 n.5 (1954); *Zenith Radio Corp.* v. *Hazeltime Research, Inc.*, 395 U.S. 100, 123 (1969).

This Court has repeatedly recognized the principle that taking a case from the jury by granting a directed verdict is permissible only in very limited circumstances. *See, Continental Ore Co.* v. *Union Carbide & Carbon Corp.*, 370 U.S. 690, 696 (1962); *Galloway* v. *United States*, 319 U.S. 372, 395 (1943); *Gunning* v. *Cooley*, 281 U.S. 90, 93 (1930); *Brady* v. *Southern Ry. Co.*, 320 U.S. 476, 479 (1943). *See generally*, 9 Wright and Miller, Federal Practice and Procedure § 2524 at 543-546; 5A J. Moore, Federal Practice, ¶ 50.02[1] at 2326-2327 (2d ed. 1974).

[50] In *Greenwood* v. *United States*, 350 U.S. 366 (1956), for example, this Court indicated that long-term hospitalization could constitutionally be justified only upon a finding of mental incompetence *and* dangerousness. In *Jackson* v. *Indiana*, 406 U.S. 715

suggest, long-term confinement of non-dangerous mentally ill persons *for treatment* is constitutionally suspect, it follows *a fortiorari* that long-term or indeterminate confinement of non-dangerous, mentally ill persons *for custodial care* is doubly suspect.

Virtually every court to consider the issue has ruled or indicated that long-term confinement of non-dangerous mental patients, solely for custodial care, is functionally indistinguishable from imprisonment for crime, and is therefore constitutionally impermissible. In *Robinson* v. *California*, 370 U.S. 660 (1962), as well as in subsequent cases, this Court has made clear that no one may constitutionally be punished for the mere "status" of being mentally ill, and that confinement of non-dangerous persons, in prison-like institutions,[51] without "treatment" would be viewed as punishment violative of the Eighth and Fourteenth Amendments.[52]

(1972), this Court cited a long list of federal decisions since *Greenwood*, all of which ruled "without exception" that "indefinite commitment on the grounds of incompetency alone," without proof of dangerousness, was impermissible. *Id.* at 731-34. Finally, in *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972), this Court noted with approval that Wisconsin, like most states, conditioned confinement "for compulsory psychiatric treatment . . . not solely on the medical judgment that the defendant is mentally ill *and treatable*, but *also* on the social and legal judgment that his potential for doing harm, to himself or to others, is great enough to justify such a massive curtailment of liberty." (Emphasis added.)

[51] *Robinson* was concerned with confinement in a "prison." But constitutional rights depend on functional realities, not on the "civil" or "criminal" label which attaches to an instiution or procedure. *Specht* v. *Patterson*, 386 U.S. 605 (1967); *In re Gault*, 387 U.S. 1 (1967). Respondent's rights cannot be abridged merely by "the hanging of a new sign—reading 'hospital'—over one wing of the jailhouse." Powell v. Texas, 392 U.S. 514, 529 (1968). *See also*, Virginia Note, note 23, *supra*.

[52] In *Martarella* v. *Kelley*, 349 F. Supp. 575, 599 (S.D.N.Y. 1972), the District Court cited *Robinson* as authority for the following principle: ". . . although the State might legally detain non-

In sum, if it chooses to reach that issue, this Court should follow the suggestions contained in its own opinions and the rulings of the courts below and hold that the provision of mere custodial care, like that provided in a prison,[53] cannot justify the involuntary confinement of a mentally ill person who is dangerous neither to himself nor to others.[54]

criminals for compulsory treatment or other legitimate purposes which protect society or the person in custody, detention for mere illness—without a curative program—would be impermissable." *See also*, *Welsch* v. *Likins*, 373 F. Supp. 487, 496 (D.Minn. 1974); *United States* v. *Walker*, 335 F. Supp. 705, 708-09 (N.D. Cal. 1971); *United States* v. *Jackson*, 306 F. Supp. 4, 6 (N.D.Cal. 1971). Commentators cite *Robinson* for the same proposition: "confinement without treatment may be regarded as punishment for a mere condition—mental illness—over which the patient has no control, a punishment of the type declared unconstitutional in *Robinson* v. *California*." *Wyatt* Comment, note 26, *supra*, at 1292. Similarly, in the opinion below, the court noted that "absent treatment, the hospital is transformed into a penitentiary where one could be held indefinitely for no convicted offense," 493 F.2d at 522, n.22, quoting from *Wyatt* v. *Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971), subsequently *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 10, 1974), which in turn quoted from *Ragsdale* v. *Overholser*, 281 F.2d 943, 950 (D.C. Cir. 1960) (Fahy, J., concurring).

See also, note 56, *infra*, for a discussion of other theories which could be used in deciding that mere custodial care was not a permissible purpose of confinement in the circumstances of this case.

[53] Furthermore, even if the mere provision of custodial care could conceivably be, in some extreme circumstances, a constitutionally permissible purpose for the involuntary confinement of the mentally ill—which respondent does not concede—such extreme circumstances were not present in this case. For example, there was no basis for a reasonable belief that respondent was in a coma, was totally paralyzed or was simply incapable of providing even custodial care for himself. *See* pp. 19-21, *supra*. Accordingly, confinement for the purpose of custodial care could not be a constitutionally permissible purpose in this case, even if it could be in others.

[54] Petitioner incorrectly asserts that "the historical basis for the existence of state mental institutions was to safeguard the

3. *This Court should not hold that provision of treatment justifies involuntary confinement of a harmless mental patient.*

Although respondent has shown that the stated purpose advanced by Florida to justify his indeterminate and involuntary confinement was the provision of treatment, respondent respectfully urges this Court not to hold that treatment is a constitutionally permissible purpose for the confinement of a harmless mental patient. As has been noted, respondent neither challenged nor conceded the permissibility of the stated purpose used to justify his confinement, choosing instead to prove the absence of a rational relationship between that purpose and the nature of his confinement. Thus, the constitutional permissibility of that treatment purpose is not before this Court and *need not* be decided. The complex question whether treatment justifies the indeterminate and involuntary confinement of a non-dangerous mental patient *should not* be decided without full briefing based upon a complete record.[55] But if this Court chooses to reach this

individual and society, and to relieve the family of the financial and physical burden of caring for the mentally ill." Petr. Brief at 42. Nor is it true, as petitioner asserts, that "treatment as a goal of confinement of the mentally ill person," did not emerge until the "first half of this century." *Id.*, at 24. *See generally*, ABF Study, *supra*, note 22, at 7-8, 34; D. Rothman, The Discovery of the Asylum 130-38 (1971).

[55] In deciding whether a state could involuntarily and indeterminately confine a non-dangerous but mentally ill individual on the basis of that individual's need for treatment, this Court would have to confront the following issues, which were not briefed or argued below: is the right infringed by the commitment "fundamental;" is the justification—need for treatment—a "compelling state interest;" is the need-for-treatment standard governing confinement impermissibly vague; does the nature of the civilly committed individual's liberty interest require that no commitment can be for an indeterminate period; is involuntary confinement in a state mental hospital the least restrictive method for accomplishing a putatively permissible state purpose?

[Footnote continued on page 55]

issue it should hold that provision of treatment is *not* an adequate justification for involuntarily confining a mental patient who is dangerous neither to himself nor to others.[56]

[55] [Continued]

Increasingly, modern civil commitment laws have abandoned commitments based solely on the *criteria* of "in need of treatment" for, while treatment remains the primary *purpose* of commitment, there is a "trend toward restricting involuntary civil commitment to the dangerous mentally ill and toward limiting the type and increasing the severity of harm necessary to support a finding of dangerousness," *Developments—Civil Commitment*, *supra*, note 26, at 1205. "The legal principles of modern commitment reform laws are intended . . . to remove the shackles of raw state power and to replace them with a more humane and sensitive balance forged from the Bill of Rights. *Our return to the standard of dangerousness has not been prompted by an interest in protecting the community from the dangerously insane but rather in protecting the mentally ill person from being involuntarily committed merely because a physician certifies that that person is mentally ill and in need of treatment.*" Flaschner, *Legal Rights of the Mentally Handicapped: A Judge's Viewpoint*, 60 A.B.A.J. 1371, 1372 (1974). (Emphasis added.) There is, further, a strong trend in modern civil commitment laws toward encouraging voluntary rather than involuntary confinement of the mentally ill. *See, e.g.*, ABF Study, *supra*, note 22, at 17-33; Wexler, *Mental Health Law and the Movement Toward Voluntary Treatment*, 62 Calif. L. Rev. 671 (1974).

[56] In brief, respondent submits that his right to be free from physical restraint was a "fundamental" due process right. *Roe* v. *Wade*, *supra*, 410 U.S. at 168-70 (Stewart, J., concurring). Alternatively, respondent's right to privacy, *Roe* v. *Wade*, *supra*, 410 U.S. at 152-54, or his right to freedom of association, *Shelton* v. *Tucker*, 364 U.S. 479, 486 (1960), or his right to travel, *Shapiro* v. *Thompson*, 394 U.S. 618, 629-31 (1969), were all abridged by his involuntary confinement. These rights are also "fundamental." Accordingly, the state must have a "compelling interest" to justify involuntary confinement. When a patient is not dangerous to self or to others and when, therefore, the state involuntarily confines under its *parens patriae* power for the benefit of the individual, a general goal of "treatment", without further specification of the harms which treatment will prevent, will not justify the abrogation of fundamental constitutional rights entailed by involuntary confinement, any more than a generalized goal of "treatment" would justify incarceration for a physcial ailment if a person

C. Due Process Required That the Nature of Respondent's Involuntary Confinement Had To Be Reasonably Related to the Purpose of That Confinement: Respondent Thus Had a Constitutional Right to Treatment Or to Release

Due process requires that the governmental means of abridging a person's protected liberties, must, at the least, bear a rational relation to the purpose of such abridgement. *Nebbia* v. *New York*, *supra*; *Meyer* v. *Nebraska*, *supra*; *Vlandis* v. *Kline*, *supra*. In the context of confinement of the mentally disabled, the rule has been succinctly stated by this Court in *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738:

> "At the least, due process requires that the *nature* and duration *of commitment bear some reasonable relation to the purpose for which the individual is committed.*" (Emphasis added.)

---

were not dangerous to self or to others. This Court has already suggested that long-term confinement of non-dangerous mentally ill patients is suspect, *see* p. 51 and note 50, *supra*. It is a long-standing rule of law in our society that there must be a knowing and voluntary consent before an individual may be given medical or psychiatric treatment. *See generally, Developments—Civil Commitment*, note 26, *supra*, at 1194-95. This basic tort principle—which may have constitutional dimensions—is abridged during involuntary confinement.

The argument presented immediately above applies *a fortiori* to demonstrate that the state may not confine a non-dangerous mental patient solely for custodial care. This argument thus complements the Eighth and Fourteenth Amendments argument on that point presented above. *See* p. 52, *supra*.

In *Lynch* v. *Baxley*, the District Court expressly said that it did not interpret the Court of Appeals' decision in this case to "raise the issue of the constitutional validity *ab initio* of the involuntary commitment of a nondangerous person for treatment or custodial purposes" or to "sanction the commitment of a nondangerous person against his will." Civ. Action No. 74-89-N (M.D. Ala. Dec. 14, 1974) (three-judge court).

Jackson involved the rights of a person charged with crime.[57] This case involves the rights of a non-dangerous mental patient who had not committed any anti-social act.[58]

Therefore, it follows *a fortiori* that during his involuntary confinement respondent had a right to be treated or to be released. As has been noted, the stated purpose and the only conceivable purpose of respondent's continued confinement was the restoration of his liberty through treatment. Thus, under *Jackson*, absent treatment, the nature of confinement bore no reasonable relation to the purpose of respondent's confinement, and continued confinement was therefore arbitrary state action in violation of the Due Process Clause of the Fourteenth Amendment. In the circumstances of this case, petitioner could have satisfied *Jackson's* elementary due process requirement either by treating or by releasing respondent.

---

[57] *Jackson* involved a mentally defective deaf mute who was committed after the court determined that he was incompetent to stand trial for two petty robberies. Since the mental and physical defects which were the cause of his inability were not likely to improve during his confinement, and it was thus unlikely that he would ever become competent to stand trial, this Court ruled that the state could only detain him under its incompetency to stand trial provisions for a reasonable period to determine if improvement were possible. Otherwise, the state was required to proceed under civil commitment provisions if it sought to confine the defendant indefinitely.

[58] Even when confinement is not justified solely under the *parens patriae* power but also under the police power and the individual has committed a criminal act, this Court has suggested that involuntarily confined individuals have a right to treatment. *See McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 250 (1972); *Humphrey* v. *Cady*, 405 U.S. 504, 514 (1972) (indefinitely committed sex offender's allegation that he was receiving no treatment was a "substantial constitutional claim"); *Murel* v. *Baltimore City Criminal Ct.*, 407 U.S. 355, 357-58 (1972) (the commitment of a "defective delinquent" should be reviewed in terms of the "criteria, procedures and treatment provided").

The right to treatment for non-dangerous, involuntarily confined mental patients has been endorsed by nearly all commentators,[59] and has received near unanimous suppore in the case law.[60] As Judge Johnson held in one of the leading cases involving the rights of involuntarily confined mental patients, *Wyatt* v. *Stickney*, 325 F. Supp. 781, 785 (M.D. Ala. 1971), *aff'd sub nom.*, *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974):

> "To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violates the very fundamentals of due process." [61]

---

[59] *See, e.g.*, Virginia Note, *supra*, note 23, at 1137; *Developments—Civil Commitment*, *supra*, note 26, at 1324-29; *see generally*, articles cited at note 26, *supra*.

[60] *See, e.g.*, *Wyatt* v. *Stickney*, 325 F. Supp. 781, 784-85 (M.D. Ala. 1971) (mentally ill), 344 F. Supp. 387, 390 (M.D. Ala. 1972) (mentally retarded), *aff'd sub nom.*, *Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974); *Welsch* v. *Likins*, 373 F. Supp. 487, 496-97 (D. Minn. 1974) (mentally retarded); *In re Ballay*, 482 F.2d 648, 659 (D.C. Cir. 1973) (mentally ill); *Martarella* v. *Kelley*, 349 F. Supp. 575, 585, 600 (S.D.N.Y. 1972), *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973) ("persons in need of supervision"); *Davis, et al. v. Watkins, et al.*, No. C 73-205 (N.D. Ohio 1974). *Cf. Burnham* v. *Department of Public Health*, 349 F. Supp. 1335, 1340 n.10 (N.D. Ga. 1972), *reversed and remanded*, No. 72-3110 (5th Cir. Nov. 8, 1974). While petitioner generally relies on the District Court's opinion in *Burnham*, Petr. Brief at 29, 38, it appears that the court in that case rejected the right to treatment only for those committed pursuant to the police power, and did not decide the issue of whether such a right exists for individuals committed solely under the *parens patriae* rationale. Moreover, the decision in *Burnham* has not generally received support in subsequent decisions, *see, e.g.*, *Welsch* v. *Likins*, *supra*, 373 F. Supp. at 495. *See also*, *Wyatt* Comment, Note 26, *supra*, at 1284, n. 11 (detailed criticism of the District Court's opinion in *Burnham*).

[61] Respondent submits that even if he had been dangerous to self or to others he, like all involuntarily confined mental patients, would have had a right to treatment or to release.

[Footnote continued on page 59]

---

[61] [Continued]

The right to treatment or to release for all involuntarily confined mental patients stems, first, from *due process* requirements. As Judge Wisdom stated:

> The second part of the theory of a due process right to treatment is based on the principle that when the three central limitations on the government's power to detain—that detention be in retribution for a specific offense; that it be limited to a fixed term; and that it be permitted after a proceeding where fundamental procedural safeguards are observed—are absent, there must be a *quid pro quo* extended by the government to justify confinement. And the *quid pro quo* most commonly recognized is the provision of rehabilitative treatment. . . .

Donaldson v. *O'Connor*, *supra*, 493 F.2d at 522. In effect, the oft-used *quid pro quo* language is short-hand for the following reasoning: involuntary confinement abridges the fundamental due process right to be free from physical restraint; abridgement of this right may only be justified by a compelling state interest; the pure police power rationale of merely incarcertaing the mentally ill for the purpose of protecting society cannot justify indefinite incarceration of a mentally ill person who has committed no anti-social act and who has not been found "dangerous" pursuant to strict procedural due process safeguards; accordingly, even if an involuntary confined person is found dangerous by a committing court, confinement can only be justified by the police power purpose *plus* the *parens patriae* rationale of restoring the person to liberty through treatment; fundamental fairness requires no less; and if there is to be a constitutionally valid relationship between the compelling state interest and the nature of confinement, treatment must be provided or else the patient must be released.

Petitioner does not make any effort to rebut the *"quid pro quo"* reasoning nor does he attempt to distinguish away, or otherwise undercut, the broad range of precedent cited by the Court of Appeals for its alternative, due process holding on the right to treatment or to release:

> Taken, together, these . . . . cases constitute a near unanimous recognition that governments must afford a *quid pro quo* when they confine citizens in circumstances where the conventional limitations of the criminal process are inapplicable.

Id., at 524. In the face of the Court of Appeals' scholarly opinion, petitioner can only assert, without any analysis or citation of authority, that "it cannot be reasonably or responsibly argued that society does not have the right under the police power theory to

D. Definition of the Right to Treatment: The Trial Court Properly Instructed the Jury That Respondent Should Have Received Such Treatment As Would Have Given Him a Reasonable Opportunity To Be Cured or To Improve His Mental Condition

Relying on only a single case, which has been reversed,[62] and on a tiny minority of commentators,[63] petitioner claims that courts are incapable of defining or enforcing the constitutional right to treatment. Petr.

---

confine mentally ill persons with a propensity for dangerous behavior, with or without accompanying treatment." Petr. Brief at 23-24.

The right to treatment or to release for all involuntarily confined mental patients is also compelled by the prohibition against cruel and unusual punishments contained in the Eighth and Fourteenth Amendments. While the due process right to treatment looks to the permissible state purpose justifying involuntary commitment, the right to treatment, when based on the guarantee against cruel and unusual punishments, stems from the conditions of confinement. Without treatment, a mental hospital is no more than a prison. *See* pp. 51-52 and note 51, *supra*. And a mentally ill person, confined without treatment, whether judged to have dangerous propensities or not, is being incarcerated as if his sickness were a crime. To so confine a person is unconstitutional. *Robinson* v. *California*, 370 U.S. 660, 666 (1962). And state authorities must, therefore, treat the patient or release him.

[62] *Burnham* v. *Department of Public Health*, 349 F.Supp. 1335 (N.D. Ga. 1972), *rev'd & remand*, No. 72-3110 (5th Cir. Nov. 8, 1974). *See* note 28, *supra*. *Burnham* is inapposite, at least in part, because the District Court did not think that the right to treatment could be enforced on an institution-wide basis but intimated that an inquiry into the adequacy of treatment could be made on an individual basis. 349 F.Supp. at 1343.

[63] See Petr. Brief at 30, n. 18 and 38-39, n.30. Not only does petitioner fail to acknowledge the broad range of legal and other commentary to the contrary, see notes 25-26, *supra*, but at least three of the five articles cited by petitioner do not stand for the proposition that the right to treatment is incapable of definition or enforcement but, in fact, conclude that it is ("Cameron" and "Katz") or are essentially non-committal on the point ("Note").

Brief at 29-45.[64] Petitioner maintains that, because there is a broad spectrum of expert opinion regarding proper treatment of the mentally ill, courts should, therefore, have no role in ensuring that involuntarily confined mental patients receive some treatment. *Id.* at 30-37, 43-44.[65]

But petitioner's arguments, once again, simply ignore the instructions and facts which make this case a narrow and easy one. In any event, respondent will demonstrate that courts can use the traditional methods of the judicial process in determining whether state officials are providing involuntarily confined mental patients with the reasonable level of treatment guaranteed by the Constitution.

1. *The instructions defining the right to treatment were correct.*

After ruling that a person civilly committed to a state mental hospital has a constitutional right to treatment or release, the Court of Appeals for the Fifth Circuit defined respondent's right to treatment in a holding that

---

[64] The question of ascertaining judicially manageable standards for measuring the rights and duties of parties is customarily viewed as an issue of justiciability, *Baker* v. *Carr*, 369 U.S. 186, 198 (1962); *accord*, *Powell* v. *McCormack*, 395 U.S. 486, 518 (1969), although petitioner does not use this term in his brief. *See*, Comment, *Wyatt* v. *Stickney, and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282, 1296-99 (1973) (right to treatment is justiciable); *Developments—Civil Commitment*, *supra*, note 26, at 1333-44 (right to treatment is justiciable).

[65] Evaluation of the reasonableness of treatment would, petitioner asserts, "force" courts into the position of "picking and choosing" among various forms of treatment, thereby "overruling decisions of trained psychiatrists." Petr. Brief at 44.

But this far-reaching contention finds *no* support in the trial records. No witness testified that it was impossible, or even difficult, to define "treatment" or "reasonable treatment" for the purpose of enforcing the right to treatment in the courts.

followed the trial court's instruction: respondent should receive "such individual treatment as will give him a *reasonable* opportunity to be cured or to improve his mental condition." *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520. (Emphasis added.)[66] This instruction defining the right to treatment follows necessarily from the due process theory establishing that right. Because respondent's right to treatment arose when the state involuntarily confined him for the purpose of treating his alleged mental illness in order to restore him to the community, then the level of treatment provided should, in fact, have given respondent a reasonable opportunity to have that illness improved or cured. Otherwise, his confinement would have been wholly arbitrary.

Not only is the instruction defining the right to treatment logically compelled, but it is also strongly supported by this Court's requirement in *Jackson* v. *Indiana*, *supra*, 406 U.S. at 738, that continued involuntary confinement by the state "must be justified by *progress* toward" the goal of that confinement. (Emphasis added.) This rule clearly justified scrutiny of the nature of the treatment provided in this case to ensure that it bore a reasonable relation to the purpose of confinement. *See Humphrey* v. *Cady*, *supra*, 405 U.S. at 514; *Murel* v. *City of Baltimore Criminal Ct.*, *supra*, 407 U.S. at 357-58. As the Supreme Judicial Court of Massachusetts has stated, *Nason* v. *Superintendent, Bridgewater Hospital*, 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968):

> "Confinement of mentally ill persons, not found guilty of crime, without affording them *reasonable* treatment also raises serious questions of deprivation of liberty without due process of law. As we said in the *Page* case, of a statute permitting comparable confinement, 'to be sustained as a non-penal statute . . . it is necessary that the *remedial aspect of confinement . . . have foundation in fact.*'" (Emphasis added; citations omitted.)

See also, Virginia Note, *supra*, at 616-19; Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282, 1286 (1973). When there is a "massive curtailment of liberty" in a constitutional sense, *Humphrey* v. *Cady*, *supra*, 405 U.S. at 509, for the purpose of treatment, then courts should review the actual treatment provided to ensure that it is reasonable; the decision whether the involuntary confinement of a mentally ill person continues to be valid after civil commitment, like the threshold decision to commit, is a "social and legal judgment," not just a medical one. *Id.*, at 509. *See also*, ABF Study, *supra*, at 171 (". . . it remains the function of law to circumscribe the decision-making powers of hospital officials.").

2. *The evidence showed, and the jury could have found, that respondent did not receive treatment, which would have provided a reasonable opportunity to cure or improve his mental condition.*

In this case, respondent sought damages for petitioner's failure to treat *or else* release him. Respondent did not seek the affirmative provision of treatment. This is, therefore, a narrow case. The jury could have found:

> First, petitioner *knew* that respondent was not getting any treatment and yet he refused to release him, although he knew respondent was dangerous neither to himself nor to others.[67]

[66] The Court of Appeals properly read the District Court's instruction that respondent had a right to "such treatment as will give him a realistic opportunity to be cured or to improve his mental condition" as a right to a "reasonable" opportunity to be cured or to improve. *Donaldson* v. *O'Connor*, *supra*, 493 F.2d at 520.

When the trial judge announced in chambers that he intended to give the instruction, petitioner did not object. T 11/28/72 at 8.

[67] *See* pp. 5-19, *supra*.

> Second, petitioner specifically withheld from respondent available treatment resources—occupational therapy and grounds privileges, for example—for reasons unrelated to his treatment needs.[68]
>
> Third, *nothing* respondent received at Florida State Hospital (and respondent received no more than custodial care) would have given him a reasonable opportunity—in fact, *any* opportunity—to be cured or to improve his mental condition.[69]

Thus, as the Court of Appeals observed, this is a case in which the jury could have decided that respondent received *no* treatment without needing further guidance from the trial court as to the definition of treatment reasonably calculated to improve or cure respondent's mental condition. *Donaldson* v. *O'Connor*, *supra*, 493 F. 2d at 526.

3. *Standards defining the right to treatment can be developed in other cases by using the traditional tools of the judicial process.*

Petitioner's broad argument that there can be *no* definition of the constitutional right to treatment, and his additional claim that enforcement of this right will impair rather than advance the provision of mental health services to involuntarily confined patients, are without merit, as the endorsement of the right by the major, professional mental health organizations demonstrates. *See Amici Curiae* Briefs submitted in No. 74-8.[70] Courts can mediate successfully between two important interests: the right of involuntarily confined patients to receive a reasonable level of treatment and the need of mental health professionals to exercise their expertise

---

[68] *See* pp. 10-14, *supra*.

[69] *See* pp. 5-14, *supra*.

[70] *See* note 25, *supra*.

within a wide range of discretion. And the constitutional right to treatment, properly understood, will not subject the vast majority of state doctors to personal liability.

Existing case law and commentary on the constitutional right to treatment demonstrates that broad and sensible guidelines for defining the right have already begun to develop. The fundamental theme of the precedent and the literature is that, when enforcing the right to treatment, courts will *not* attempt to prescribe specific forms of treatment for specific patients, but will limit their review to determining whether some form of treatment recognized by responsible professionals is being provided. In conducting that review, courts will ordinarily look to good faith efforts by state officials to provide treatment that is within the broad range of accepted professional practice. In reality, the right to treatment suits which have been brought to date—whether of a class or individual nature—have involved state hospital conditions or officials acts which were so substandard that there could be unanimity among responsible professionals and professional groups that a reasonable level of treatment was not being provided. *See, e.g.*, *Wyatt* v. *Aderholt*, *supra*, slip opn. at 722 (even defendants conceded that they were not providing reasonable treatment). *See also Welsch* v. *Likins*, 373 F. Supp. 487, 496 (D. Minn. 1974).

More specifically, the following guidelines for defining the right to treatment have emerged from both individual and class actions.

First, judicial enforcement of the right has not, thus far, required doctors to demonstrate that a particular course of treatment would cure or improve the patient's mental condition, but only to show that there was a *bona*

fide effort and a reasonable opportunity to cure or improve that condition.[71]

Second, courts have allowed state authorities broad discretion, within the range of present knowledge, in their efforts to treat the mentally ill.[72]

Third, courts have not required state officials to provide the "best possible treatment" but only treatment that is "adequate" or "reasonable" within the range of accepted professional practice.[73]

Fourth, courts can determine what is or is not accepted professional practice through published professional standards,[74] position papers of expert organiza-

[71] *See, e.g., Rouse* v. *Cameron*, 373 F.2d 451, 456-7 (D.C. Cir. 1966); *Wyatt* v. *Stickney, supra*, 325 F.Supp. at 785, *aff'd sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974).

[72] *Rouse* v. *Cameron, supra*, 373 F.2d at 456 (government authorities have an obligation to provide treatment that comes within the range of "present knowledge").

[73] *Tribby* v. *Cameron*, 379 F.2d 104, 105 (D.C. Cir. 1967) (Edgerton, J.: "We do not suggest that the court should or should can decide what particular treatment this patient requires . . . We do not decide whether the [government] has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion."); *In re Jones*, 338 F.Supp. 428, 429 (D.D.C. 1972). *Cf. Dobson* v. *Cameron*, 383 F.2d 519 (D.C. Cir. 1967) (en banc) (Burger, J., concurring: ". . . it can be argued that Congress has conferred some power on us at least to inquire into civil commitment cases when it is alleged that one is being detained *without any* treatment."). (Emphasis added.)

[74] *See, e.g.*, Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972). The Joint Commission is comprised of members from the following organizations: American Academy of Child Psychiatry, American Association on Mental Deficiency, American Hospital Association, American Psychiatric Association, National Association of Private Psychiatric Hospitals, National Association of State Mental Health Program Directors, National Council of Community Mental Health Centers. *See also*, American Psychiatric Association, Standards for

tions,[75] and expert testimony.

Fifth, when evaluating the adequacy of treatment,[76]

Psychiatric Facilities (1974 ed.); American Psychological Association Task Force on Standards for Service Facilities, Standards for Providers of Psychological Services (1974).

[75] *See, e.g.*, American Psychiatric Association Task Force on the Right to Care and Treatment, Draft Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded (Oct. 1974); American Psychiatric Association, Position Paper on Involuntary Hospitalization of the Mentally Ill, 130 Am.J.Psychiatry (1973); National Association for Mental Health, Position Statement on the Right to Treatment (1970). Material on standards and adequate treatment is also found in such leading professional journals as The American Journal of Psychiatry, The Archives of General Psychiatry, The Journal of the American Medical Association, Mental Hygiene, The American Journal of Orthopsychiatry, Journal of Clinical Psychology and the Journal of Nervous and Mental Diseases.

[76] To date courts have not required state officials to prove that treatment has been "effective." *Cf.* Schwitzgebel, *The Right to Effective Mental Treatment*, 62 Cal. L. Rev. 936 (1974) (right to treatment should be measured by whether patient's mental illness *will be* cured or improved). There is, however, strong support for this further requirement in *Jackson* v. *Indiana, supra*. There, this Court unanimously ruled that continued confinement on the grounds of incompetence to stand trial could be justified only if there was "progress" toward the goal of restoring competence. 406 U.S. at 738. That ruling was consistent with, and perhaps required by, the Court's admonition in *Jackson* that not only the "nature" but also the "duration" of confinement must bear some reasonable relation to the purpose of confinement. That is, unless treatment is "effective" in the sense that there is "progress" towards cure or improvement, continued confinement would not bear a reasonable relation to the purpose of confinement. *Jackson* thus suggests a limited and indirect standard for reviewing the effectiveness of treatment. If, after a reasonable period of time, there has been "no progress" toward a permissible goal; the reviewing court could conclude that the treatment provided has not been effective, and therefore, that further treatment would not give the patient a "reasonable opportunity" for cure or improvement. *See also, McNeil* v. *Director, Patuxent Institution*, 407 U.S. 245, 249-52 (1972), where this Court also imposed a due process time limit on confinement for observation.

courts can utilize *amici curiae*, ombudsmen or human rights committees.[77]

The workability of these guidelines is already evident in suits seeking *institution-wide relief*. For example, in *Wyatt* v. *Stickney*, 334 F. Supp. 1341, 1343 (M.D. Ala. 1971), *affirmed sub nom.*, *Wyatt* v. *Aderholt*, *supra*, a class action seeking declaratory and injunctive relief, the District Court held that there were three fundamental conditions which were necessary for adequate treatment of the civilly committed: (1) a humane psychological and physical environment; (2) qualified staff in numbers sufficient to administer adequate treatment; and (3) individualized treatment plans. In reaching this conclusion, the Court relied on extensive participation in the case by professional organizations and by the United States as *amici curiae*. These three conditions constitute professional and constitutional minima which must be met if the involuntarily confined patient's right to treatment is to be protected. These conditions have received wide endorsement.[78] And they reflect application of the

[77] National mental health organizations participated extensively in *Wyatt* v. *Aderholt*, *supra*, both at the trial level and on appeal. These groups were the American Orthopsychiatric Association, the American Psychological Association, and the American Association on Mental Deficiency (at trial and on appeal) and the American Psychiatric Association and the National Association for Mental Health (on appeal). As the Court of Appeals noted, "The District Court expressed its gratitude to these organizations for their valuable assistance in this difficult and complex case, 344 F. Supp. 375, 390, and we do so, too." *Id.*, slip opn. at 719 n. 3. *See generally*, *Developments—Civil Commitment*, *supra*, note 26, at 1340-41.

[78] There is widespread agreement among professional organizations active in the mental health area on the need for all three conditions as an absolute minimum, without which there can be no treatment reasonably calculated to improve or to cure patients' conditions.

With respect to staffing patterns there is consensus that adequately trained personnel in sufficient numbers is an essential component of treatment effectiveness. Specific staffing ratios can be set based on the goals of the individual facility, the types of patient served, geographic location and other factors. *See*, *e.g.*, American Psychiatric Association, Standards for Psychiatric Facilities (1974 Revision/Addendum) (Standard 14-A); American Psychiatric Association, Standards for Psychiatric Facilities (1969) (Standards 28, 30-32); Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972).

Similarly, there is universal agreement that a "humane physical and psychological environment" is a *sine qua non* of effective treatment. And indices have been developed with respect to nutrition, space, ventilation, bathing facilities and other aspects of a patient's daily life. *See*, *e.g.*, American Psychiatric Association, Standards for Psychiatric Facilities (1974 Revision/Addendum) (Principle B and Standard 21-A); American Psychiatric Association, Standards for Psychiatric Facilities (1969) (Standards 29, 39 and 44); Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972).

Finally, there is unanimity that individual treatment plans are necessary both for effective treatment of patients and for responsible review by mental health professionals (not simply courts) of the quality of care received by the civilly committed mentally ill (as well as other types of medical and psychiatric patients). Moreover, there is consensus on what general information should be included in such plans. *See*, *e.g.*, American Psychiatric Association, Standards for Psychiatric Facilities (1969) (Standards 10 and 34); Joint Commission on Accreditation of Hospitals, Accreditation Manual for Psychiatric Facilities (1972).

guidelines outlined above, since they look to objective professional standards in establishing intelligible constitutional standards which will leave substantial discretion in the hands of mental health professionals. Moreover, to facilitate judicial administration of the right to treatment, the *Wyatt* court confined itself to the "increasingly common procedure of permitting the parties to fashion their own relief and then reviewing its reasonableness." Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 Harv. L. Rev. 1282, 1298-99 (1972). *See also*, *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974).

The guidelines also are workable with respect to *individual* actions seeking damages or an injunction prohibit-

ing provision of inadequate treatment. For example, if a mentally ill person were confined because of psychotic depression, the state authorities could choose from a wide range of professionally accepted treatments such as chemotherapy, psychotherapy, group therapy, or occupational therapy. A reviewing court would merely decide that the treatment in question was within a professionally accepted range of treatment modes when denying the patient's claim. However, if the patient was not being given any professionally recognized treatment, then relief might lie, assuming other legal requirements were satisfied.

Petitioner's arguments about the non-justiciability of the right to treatment and the "devastating effects" its recognition will have on the Florida mental health system are directly refuted by recent Florida legislation. The Baker Act provides for a right to individual dignity, a right to treatment and a definition of the quality of treatment for those who are involuntarily confined in state hospitals. Title 27 Florida Statutes § 394.459 (July 1, 1972).[79] Obviously, the Florida legislature—and many

[79] Section 394.459(1) provides, in part:

"(1) *Right to individual dignity*: The policy of the state is that the individual dignity of the patient shall be respected at all times and upon all occasions. . . . Treatment shall be provided to the patient by his physician or the receiving facility staff. No person who is receiving treatment for mental illness in a hospital shall be deprived of any constitutional rights."

Section 394.459(a) provides, in part:

"(2) *Right to treatment*:—The policy of the state is that the Department [of Mental Health] shall not deny treatment for any mental illness to any person. . . ."

Section 394.459(4) provides, in part:

"(4) *Quality of treatment*: (a) Each patient in a facility shall receive treatment suited to his needs, which shall be administered skillfully, safely and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational and rehabilitative services as his condition requires to bring about his early return to his community."

other legislatures as well—does not consider the right to treatment non-justiciable, and has established a statutory right to treatment which may, properly, be more expansive than the right to treatment required by the Constitution.[80]

In short, judicial administration of the right to treatment would be no more difficult than court supervision of many other issues involving psychiatry or medicine. *See generally*, J. Katz, J. Goldstein & A. Dershowitz, Psychoanalysis, Psychiatry and the Law (1967); R. Slovenko, Psychiatry and Law (1973). For example, civil commitment itself is based on the premise that the courts can recognize mental illness and determine that such illness requires treatment. "If the right to treatment is non-justiciable, however, it is hard to imagine how a court can initially decide that a person is in need of treatment or that a person would benefit from involuntary hospitalization." *Developments—Civil Commitment*, *supra*, at 1336, n.86. Moreover, it is obvious that courts are continuously involved in deciding legal questions with an important medical or psychiatric dimension, when there has not yet been "finality of judgment", *Greenwood*

In January 1974, William D. Rogers, Director of the Florida Division of Mental Health, promulgated a Manual of Rights of Patients to guide implementation of the new legislation. In that manual (at 15-16), Rogers states: "The hospitals and facilities of the Division are not punitive or merely custodial; they exist to provide quality treatment for those patients committed to them. *If a hospital fails to provide quality treatment, its reasons for being must be seriously questioned and certainly its legal justification for involuntary commitment disappears.*" (Emphasis added.)

For a discussion of the damages provision of the new law which imposes liability on state doctors, *see* pp. 84-85, *infra*.

[80] For a discussion of statutory right to treatment provisions, *see Developments—Civil Commitment*, *supra*, note 26, at 1319-24.

v. *United States*, *supra*, 350 U.S. at 375,[81] and which require reconciling state interests and individual rights in such areas as the insanity defense,[82] drug-related offenses,[83] the adequacy of medical care afforded prisoners,[84] conditions in prisons,[85] and malpractice.[86] *See Roe*

[81] Petitioner cites *Greenwood* for the proposition that there is not universal agreement among mental health professionals about what constitutes proper treatment. Petr. Brief at 34. But, as the right to treatment has been implemented in the lower courts, that perception has been taken into account. As has been discussed, *see* pp. 65-70, *supra*, to satisfy their duty to vindicate the right to treatment state officials need only provide a form of treatment that falls within a wide range of professionally accepted choices.

United States v. *Klein*, 325 F.2d 283, 286 (2d Cir. 1963), Petr. Brief at 33, is inapposite for the same reason. The issue in the case was whether a particular treatment might aid Klein in becoming competent to stand trial. The Court of Appeals stated that under 18 U.S.C. § 4246 courts did not have authority to choose which " of two equally *reputable methods* of psychiatric treatment would prove most efficacious in a particular case." *Klein*, *supra*, at 285. (Emphasis added.) When enforcing the constitutional right to treatment, courts would not make such decisions either.

[82] *See generally*, J. Katz, J. Goldstein and A. Dershowitz, *Psychoanalysis, Psychiatry and Law* 526-98 (1967); R. Slovenko, *Psychiatry and Law* 77-91 (1973); A. Goldstein, *The Insanity Defense* (1968).

[83] *See, e.g., Robinson* v. *California*, 370 U.S. 660 (1962); *Easter* v. *District of Columbia*, 361 F.2d 50 (D.C. Cir. 1966); *Slovenko*, *supra*, note 82, 143-73.

[84] *See, e.g., Martinez* v. *Mancusi*, 443 F.2d 921 (2d Cir. 1970), *cert. denied*, 401 U.S. 983 (1971); *Blanks* v. *Cunningham*, 409 F.2d 220 (4th Cir. 1969).

[85] *See, e.g., Holt* v. *Sarver*, 442 F.2d 304 (8th Cir. 1971); *Landman* v. *Royster*, 354 F. Supp. 1302 (E.D. Va. 1973).

[86] *See, e.g., Whitetree* v. *State*, 56 Misc.2d 693, 290 N.Y.S.2d 486 ,Ct. Cl. 1968) ($300,000 in damages awarded to patient for confining him because of incompetence to stand trial and then failing to provide treatment). Petitioner claims that there are very few malpractice cases in the psychiatric area and that the courts have exhibited reluctance in trying to decide when negligence has occurred in treatment matters. Petr. Brief at 37. *But see*, R. Slovenko, *supra*, note 82 at 394-433 ("Psychiatric Tort and Other Liability"). D. Dawidoff, The Malpractice of Psychiatrists (1973).

v. *Wade*, 410 U.S. 113 (1973); *Doe* v. *Bolton*, 410 U.S. 179 (1973). And, more generally, it is obvious, too, that courts are often required to consider complex and technical matters in deciding a host of statutory and constitutional cases that affect competing interests.[87]

Accordingly, this Court should hold that respondent had a constitutional right to treatment or to release and that the trial court's instruction defining the right to treatment was correct in the circumstances of this case. Standards governing further definition of the right can be developed, on a case by case basis, by those federal and state courts which are called upon to consider claims involving alleged deprivation of the constitutional right to treatment. By so holding, this Court can ensure that the most basic liberties of vulnerable individuals—those who are involuntarily confined for mental illness—are accorded the reasonable protection that the Constitution guarantees.

Finally, it should be emphasized that a state official's failure to provide treatment will not of itself subject the official to liability in damages. Habeas corpus actions or actions seeking declaratory and injunctive relief will ordinarily serve to vindicate individual rights. As will be discussed in Part II, *infra*, damages will only lie in those hopefully rare instances when the judge or jury finds that, as here, the state official both denied the right to treatment or release and failed to act in good faith.

[87] *See generally*, L. Tribe, Channeling Technology Through Law (1973). When the state intrudes upon constitutionally protected liberties, the intrusion raises social and legal questions and is not simply to be left to the uncontrolled discretion of experts.

II. IN THE CIRCUMSTANCES OF THIS CASE, THE AWARD OF COMPENSATORY AND PUNITIVE DAMAGES SHOULD BE AFFIRMED

Under the instructions in this case, in order to award damages, the jury had to find (a) that petitioner knew respondent was not dangerous;[88] (b) that petitioner knew respondent received only custodial care;[89] *and* (c) that petitioner did not reasonably and in good faith believe that respondent's continued confinement was lawful.

The judge instructed the jury as follows (A at 184):

> "If the Jury should believe from a preponderance of the evidence that the Defendants *reasonably believed in good faith* that detention of Plaintiff was proper for the length of time he was so confined then a verdict for Defendants should be entered *even though the jury may find the detention to have been unlawful.*
>
> "However, mere good intentions which do not give rise to a *reasonable belief that detention is lawfully required* cannot justify Plaintiff's confinement in the Florida State Hospital." (Emphasis added.)

Thus, under the instructions, before awarding damages the jury had to find that respondent's continued confinement was unlawful *and* that petitioner *knew* it was unlawful.

[88] *See*, p. 39, *supra*.

[89] *See*, p. 40, *supra*.

A. No Legal Issue Regarding Damages Is Before This Court Because Petitioner Did Not Object to the Relevant Jury Instructions, Either at Trial or on Appeal

1. *The good faith and reasonableness defense.*

As the Court of Appeals noted, "the trial judge instructed the jury to find for the defendants if it found the defendants acted in good faith; and . . . the defendants have not challenged the propriety or phrasing of this instruction." 493 F.2d at 530. Although petitioner does challenge the sufficiency of the evidence to support the verdict, he did not object to that instruction below, nor does he challenge it here.[90]

Moreover, under the instructions relating to the award of *punitive* damages, the jury was required to find not only that petitioner did not reasonably and in good faith believe respondent's confinement was lawful or proper, but also that petitioner's acts constituted "extraordinary misconduct" and were "malicious, wanton or oppressive." T Oral Charge 11/28/72 at 16-18. Again, petitioner did not object to this instruction as given below and does not challenge its correctness here. T 11/28/72 at 54-56.

[90] Although petitioner and his co-defendants did not object to the damages instructions that *were* given, they did object to the trial court's refusal to give an additional instruction that would have entitled them to claim "quasi-judicial immunity." Defendants' Proposed Instruction No. 11 read: "If you find that the defendants were operating in a quasi-judicial function, in that they, under state law, were making a judgment as to whether or not plaintiff should be released, defendants are immune from liability under the Civil Rights Act." In an Instructions Conference in chambers, that proposed instruction was refused. T 11/28/72 at 10. Petitioner did not appeal the refusal to give that instruction. His co-defendant John Gumanis did appeal that issue. 493 F.2d at 529. The Court of Appeals ruled that state hospital officials are entitled to claim good faith as a defense but are not entitled to claim quasi-judicial immunity, and that the refusal to give the proposed instruction was therefore proper. 493 F.2d at 529-30. Petitioner has not raised the refusal to give a "quasi-judicial immunity" instruction as an issue in this Court.

2. *The "retroactivity" claim.*

The only *legal* issue regarding damages raised by petitioner in this Court is his claim that the award is based on "the retroactive application" of a newly declared right. Petr. Brief at 16. Petitioner *did not raise this claim at trial, and it was not raised, briefed or argued on appeal.*[91] There is no discussion of this claim in the opinion below. Accordingly, there is no legal issue regarding daamges properly before this Court.[92]

---

[91] At no point during the trial did petitioner seek to introduce evidence that would provide factual support for a retroactivity claim, and there is no such evidence in the record. The closest petitioner came to addressing this point was Defendants' Proposed Instruction No. 15, which provided: "You are instructed that if defendants acted pursuant to a statute which was not declared unconstitutional at the time, they can not be held accountable for such action." During the Instructions Conference in chambers, the trial judge announced that he would not give that instruction. T 11/28/72 at 11. Petitioner did not object to that refusal. *Id.* The refusal was quite proper, first, because the substance of the instruction was covered in the good faith instructions which the court did give, and second, because there was literally no evidence that petitioner believed or even claimed that he was required or authorized by any statute to continue to confine a non-dangerous patient who was receiving no treatment.

[92] As stated in *Lawn* v. *United States*, 355 U.S. 339, 362, n. 16 (1958), *rehearing denied*, 355 U.S. 967 (1958), "Only in exceptional cases will this Court review a question not raised in the court below." *See also*, *Adickes* v. *S. H. Kress and Co.*, 398 U.S. 144, 147, n. 2 (1970); *Duignan* v. *United States*, 274 U.S. 195, 200 (1927), and cases cited therein; and *Husty* v. *United States*, 282 U.S. 694, 701-02 (1930). Although a party may raise a constitutional question for the first time in this Court it is clear that the retroactive or prospective application of a ruling in itself raises no constitutional questions: "[T]he federal constitution has no voice upon the subject." *Great No. Ry.* v. *Sunburst Oil & Refining Co.*, 287 U.S. 358, 364 (1932) (Mr. Justice Cardozo); *accord*, *Linkletter* v. *Walker*, 381 U.S. 618, 629 (1965) ("[T]he Constitution neither prohibits nor requires retrospective effect.").

B. The Jury Instructions Relevant to the Award of Damages Were in Accord With Applicable Law

Even assuming, *arguendo*, that legal issues regarding damages are properly before this Court, respondent will demonstrate in this section that the award of damages was in accord with applicable law.

1. *The good faith and reasonableness defense.*

Under the civil rights acts only legislators and judges have absolute immunity. *Tenney* v. *Brandhove*, 341 U.S. 367, 376-77 (1951) (legislators); *Pierson* v. *Ray*, 386 U.S. 547 (1967) and *Bradley* v. *Fisher*, 80 U.S. 335, 347-49 (1871) (judges). As petitioner rightly concedes, "state officers and employees are not entitled to the absolute immunity accorded the judiciary, because that would frustrate the intent of Title 42 U.S.C. § 1983 . . . state employees and administrators should be required to act as reasonable and responsible men. . . ." Pet. for *Cert.* at 39; *see also*, Petr. Brief at 54. A "qualified immunity" is, however, available to officers or employees of the executive branch. And the breadth of this defense depends upon "the scope of discretion and responsiblities of the office and all the circumstances as they reasonably appeared at the time of the action on which liability is sought to be based." *Scheuer* v. *Rhodes*, 416 U.S. 232, 247 (1974).

The trial court decided on the wording of the "good faith" instruction after carefully reading *Pierson* v. *Ray*, *supra* (T 11/28/72 at 49), and the instruction parallels the language of that case with notable fidelity. *Pierson* involved police officers who were alleged to have falsely arrested and imprisoned petitioners in deprivation of their civil rights. This Court held (386 U.S. at 557):

> ". . . if the jury found that the officers *reasonably* believed *in good faith* that the arrest was constitutional, then a verdict for the officers would follow

even though the arrest was in fact unconstitutional." (Emphasis added.)

Here the jury was instructed that if petitioner reasonably believed in good faith that respondent's confinement was lawful, a verdict for petitioner would follow even though his confinement was in fact unlawful.

This dual requirement of good faith and reasonableness has been consistently applied by this Court. In *Scheuer* v. *Rhodes*, *supra*, for example, this Court delineated the potential liability in damages of a state Governor who was acting within the broadest possible range of discretion, during what he believed was an emergency. And even in those circumstances, this Court held:

> "[I]t is the existence of *reasonable grounds* for the belief formed at the time and in light of all the circumstances, coupled with *good faith belief* that affords basis for qualified immunity of executive officers." 416 U.S. at 247-48. (Emphasis added.)

No broader defense is appropriate here. To the contrary, petitioner properly received the same qualified immunity based upon good faith and reasonableness which has been considered sufficient to protect such executive employees and administrators as: police officers, *Pierson*, *supra*; university officials, *Handverger* v. *Harvill*, 479 F.2d 513, 516 (9th Cir. 1973), *cert. denied*, 414 U.S. 1072; FBI agents, *Jones* v. *Perrigan*, 459 F.2d 81, 83 (6th Cir. 1972) and *Bivens* v. *Six Unknown Named Agents*, 456 F.2d 1339, 1341 (2d Cir. 1972); town officials, *Harrison* v. *Brooks*, 446 F.2d 404, 407 (1st Cir. 1971); directors of state departments of mental health and program coordinators on wards, *Wheeler* v. *Glass*, 473 F.2d 983, 985 (7th Cir. 1973); directors of state institutions for "defective delinquents," *Mitchell* v. *Boslow*, 357 F.Supp. 199, 202-03 (D.Md. 1973); court clerks, *McCray* v. *Maryland*, 456 F.2d 1, 5-6 (4th Cir. 1972);

and governors, *Scheuer*, *supra*. Thus, because petitioner does not challenge the legality of the instructions regarding the good faith and reasonableness defense, and because the instruction given comports fully with the relevant precedent, petitioner's objection to the verdict can only be with the sufficiency of the evidence (see discussion in section II.C., *infra*).

2. *The "retroactivity" claim.*

Petitioner's assertion, raised now for the first time, that he "should not be held personally liable for the deprivation of a constitutional right [to treatment], whose emergence and enforcement could not have been reasonably foreseen" (Petr. Brief at 52)[93] has no rele-

---

[93] In § 1983 damage actions, it is well established that state officials can be held liable for deprivation of constitutional rights that had not previously been declared, but the emergence of which could reasonably have been foreseen. *See*, *Adickes* v. *S. H. Kress and Co.*, *supra*, at 232-33 (Brennan, J., concurring in part and dissenting in part):

> "I think it just and faithful to the statutory purpose to impose the loss on the discriminator, even if he was unaware that his discrimination constituted state action denying equal protection. Proof of an evil motive or of a specific intent to deprive a person of a constitutional right is generally not required under § 1983 [citing cases]. And, indeed, in *Nixon* v. *Herndon*, 273 U.S. 536, 47 S. Ct. 446, 71 L. Ed. 759 (1927), and *Lane* v. *Wilson*, 307 U.S. 268, 59 S. Ct. 872, 83 L. Ed. 1281 (1939), this Court upheld complaints seeking $5,000 recoveries from state election officials who merely carried out their official duty to prevent the plaintiffs from voting under discriminatory state statutes which made them ineligible to vote."

See also, *Landman* v. *Royster*, 354 F. Supp. 1302, 1317 (E.D. Va. 1973) ($21,000 judgment against Director of Division of Corrections for causing prisoners physical and psychic damage in violation of their constitutional rights); *Wheeler* v. *Glass*, 473 F.2d 983, 985 (7th Cir. 1973) (damage action by two retarded persons for having been spreadeagled on bed for 77½ hours in violation of their Eighth Amendment rights because of alleged homosexual act); *Jobson* v. *Henne*, 355 F.2d 129 (2d Cir. 1966) (damage action for involuntary servitude by retarded resident

against director and assistant directors of state school); *Anderson* v. *Nosser*, 456 F.2d 835 (5th Cir. 1972) (superintendent of prison liable for imposing summary punishment on prisoner in violation of due process); *York* v. *Story*, 324 F.2d 450, 456 (9th Cir. 1963) (female plaintiff's allegations of violations of right to privacy by police officers taking intimate photos stated cause of action under § 1983); *Wright* v. *McMann*, 460 F.2d 126, 129 (2d Cir. 1972) (prison warden could be held personally liable under Eighth Amendment for leaving prisoner in unsanitary strip cell without clothing or elements of basic hygiene); *Winters* v. *Miller*, 446 F.2d 65 (2d Cir. 1971), *cert. denied*, 404 U.S. 985 (1971) (damage action by Christian Scientist mental patient against hospital staff for violation of First Amendment rights by enforced medication).

On the other hand, the reasonable belief and good faith defense applied in § 1983 cases would certainly protect public officials who had *reasonably* relied on existing legal or professional standards that were later found to be in violation of the Constitution. Notably, when a party has been insulated from damages because he reasonably believed his actions (later ruled unconstitutional) were lawful, reliance of the party on a prior ruling or regulation or custom has been an important part of the reasonable belief defense. *Huotari* v. *Vanderport*, 380 F.Supp. 645, 651 (D.Minn. 1974) (reliance on statute permitting warrantless arrest); *Taylor* v. *Perini*, 365 F.Supp. 557 (N.D. Ohio 1972) (reliance on "statutes, regulations and procedures which he believed entirely proper" in putting plaintiff in solitary prior to transfer); *McKinney* v. *DeBord*, 324 F.Supp. 928 (E.D. Cal. 1970) (reliance on prison regulation); *Kirstein* v. *Rector & Visitors of the University of Virginia*, 309 F.Supp. 184 (E.D. Va. 1970) (reliance on standard college admission procedure).

In this case, however, petitioner has cited no evidence, and there is none, that he relied on any established legal or professional standards to justify the continued confinement of respondent, a non-dangerous patient who was receiving no treatment. In his brief at 11-12, petitioner refers to various habeas corpus proceedings, usually *pro se*, initiated by respondent. Despite numerous attempts, respondent never succeeded in obtaining a hearing on his contentions that he had been illegally committed, was not mentally ill or dangerous, and received no treatment. So far as respondent's counsel have been able to determine, all of those proceedings were dismissed on jurisdictional, procedural, or other non-constitutional grounds not relevant to the issues before this Court. Petitioner does *not* assert, nor could he given the nature of those dismissals, that he relied upon those dismissals to justify his knowing deprivation of respondent's constitutional right to liberty.

vance to the facts of this case or to the instructions given to the jury. Petitioner was *not* held liable because he failed or was unable to provide respondent with treatment, but because petitioner "*confined* plaintiff against his will, *knowing* that he was not mentally ill or dangerous or *knowing* that if mentally ill he was *not receiving treatment* for his alleged mental illness." A at 183. (Emphasis added.) It was petitioner's failure to *release* respondent, knowing he was not receiving treatment—the stated purpose justifying the confinement—which created liability. Thus, petitioner's claim that because of the limited resources of Florida State Hospital he could not provide treatment, or adequate treatment, is irrelevant. If he had not had the power to *release* respondent, then petitioner's failure or inability to *treat* respondent would not have subjected him to liability under the instructions in this case. The constitutional right petitioner abridged, the right to liberty—the right to be free from unjustified restraint—is not a new or novel right. It is perhaps the oldest and most fundamental right of civilized man. He who continues to deprive another of liberty always bears the risk of liability if he fails to justify that continuing deprivation. *Bolling* v. *Sharpe*, 347 U.S. 497, 499-500 (1954); *Whirl* v. *Kern*, 407 F.2d 781 (5th Cir. 1969), *cert. denied*, 396 U.S. 901 (1969). Under the instructions in this case, the burden of justification would have been met if the jury had found either that respondent was dangerous (or that petitioner reasonably believed him to be dangerous) (A at 186); that respondent was receiving some form of treatment other than "mere custodial care" (A at 186), *or* that petitioner "reasonably" believed that respondent's confinement was "lawfully required." A at 184.

Furthermore, the theory under which this case was actually tried—that, absent treatment, respondent had a constitutional right to be *released*—did not seem "novel"

to petitioner. To the contrary, one of the instructions proposed by petitioner, but refused by the court on the ground that it was already covered (T 11/28/72 at 9), would have authorized the jury to find a *constitutional* violation if they believed petitioner confined plaintiff knowing he was not receiving treatment, and "adequate" treatment, at that (Defendants' Proposed Instruction No. 8):

> "If you believe that defendants, without fault of plaintiff, withheld psychiatric treatment from plaintiff, *or allowed his confinement to continue knowing that he was not receiving adequate treatment*, you may find that his confinement was illegal under the federal constitution and the Civil Rights Act." (Emphasis added.)

Finally, the jury found not only that petitioner obstructed respondent's release without a reasonable belief in the legality of his conduct, but also that petitioner acted "maliciously or wantonly or oppressively" (T Oral Charge 11/28/72 at 16-18), and the Court of Appeals agreed that the evidence justified the award of punitive damages. 493 F.2d at 531. The jury finding that petitioner's conduct "maliciously or wantonly or oppressively" injured respondent vitiates any possible claim by petitioner that he subjectively, let alone "reasonably," believed his conduct to be lawful.

Thus, petitioner cannot claim surprise that his acts resulted in liability, and there is no valid retroactivity issue in this case.

C. The Award of Compensatory and Punitive Damages Is Supported by the Evidence

As noted, the jury found that petitioner *knew* that liberty is a constitutionally protected right, and *knew* that he had deprived respondent of liberty without lawful justification.[94]

Petitioner's rhetoric about his good faith and about the unfairness of the jury verdict is misplaced in view of the jury's finding, affirmed by the Fifth Circuit, that petitioner acted "maliciously, wantonly or oppressively," in blocking respondent's release to responsible and interested friends and organizations. 493 F.2d at 515, 531, and generally at 510-18.[95] The many facts supporting the jury's award have been set forth at pp. —— above.

The trial judge, who was most familiar with the facts, denied petitioner's post-trial motion for a directed verdict and for a new trial, in which petitioner alleged that the evidence did not support the award. Accord-

---

[94] So important is liberty that federal courts have ruled that damages can be awarded against state officials who illegally deprive others of liberty *even though* such officials did not, in fact, know the confinement was unlawful, and even though the confinement was for a much shorter period of time than that involved in this case. *See e.g., Whirl* v. *Kern*, 407 F.2d 781 (5th Cir. 1969), *cert. denied*, 396 U.S. 901 (1969), in which plaintiff sought damages from a sheriff who had kept him in jail for nine months after dismissal of indictments for two felonies, even though the sheriff alleged he did not know the indictments had been dismissed:

> "Ignorance . . . by a jailer should not vitiate the rights of a man entitled to his freedom. . . . The law does not hold the value of a man's freedom in such low regard." 407 F.2d at 792.

Certainly, therefore, in this case, where petitioner "knew" the confinement was unlawful, damages are justified.

[95] The question whether an objective or subjective standard is appropriate in assessing a defendant's "good faith effort" is now pending before the Court in *Wood* v. *Strickland, cert. granted*, 42 U.S.L.W. 3584 (U.S. No. 73-1285, April 15, 1974). In respondent's view, the jury finding of maliciousness in this case would support a finding of lack of good faith and reasonableness under either an objective or a subjective standard.

ingly, four federal judges have reviewed the record and have found ample evidence to support the award.

Petitioner advances no reason why this Court should again review the sufficiency of the evidence;[96] but if it does, it should affirm.

D. Affirmance of the Award of Damages Will Not Disrupt Florida's Mental Health System

Petitioner contends that if the verdict is affirmed, "competent staff will be driven away from inadequate institutions. . . ." Petr. Brief at 29.[97] In fact, however, affirmance will not disrupt the operation of Florida's mental health system, because Florida now provides, by statute, a right to treatment[98] and a civil damages remedy for persons confined without treatment. The Baker Act provides liability in damages for mental health professionals who do not act in "good faith in compliance with the provisions" of the Act:

> "(12) LIABILITY FOR VIOLATIONS—Any person who violates or abuses any rights or privileges of patients provided by this act *shall be liable for*

[96] *See*, n. 49, *supra*, for authority on the very limited scope of this Court's review of facts.

[97] A similar contention is raised in the Brief *Amicus Curiae* of American Psychiatric Association. But see the comments of the Second Circuit in *Wright* v. *McMann*, *supra*, at 135, in which a prison warden who was assessed damages under § 1983 made an analogous claim:

> "We are not moved by the suggestion that if we uphold liability today competent persons tomorrow will refuse to become superintendents, as the title is presently designated. In the unlikely event that a prospective superintendent in fact turns down an offer for fear of personal liability, we think that the position is probably better filled by someone determined to supervise the facility so as to prevent [constitutional deprivations]. . . ."

[98] *See*, text at pp. 70-71, and note 79, *supra*.

> *damages* as determined by law. A physician . . . or hospital officer or employee . . . who acts *in good faith in compliance with the provisions of this part*, shall be immune from civil or criminal liability for his actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility." Title 27, Florida Statutes Annotated, §§ 394.459(3)(a), and (12). (Emphasis added.)

Under the Baker Act, state hospital employees in Florida are already subject to a greater risk of liability than they would be under the jury instructions in this case.[99] Thus, petitioner cannot reasonably contend that affirmance of the verdict in this case will discourage psychiatrists from working in Florida mental hospitals.[100]

E. Petitioner's "Waiver" Argument Is Not Properly Before This Court, and Is Without Merit

Petitioner contends that respondent refused certain forms of treatment and therefore "by word and deed, effectively waived his right to treatment." Petr. Brief at 15. That contention was embodied in Defendants' Pro-

[99] Furthermore, in January of 1974, William D. Rogers, Director of the Florida Division of Mental Health and a defense witness in this case, promulgated a *Manual of Rights of Patients* designed to implement the Baker Act. This manual provides that "the hospitals and institutions of the Division are not punitive or merely custodial; they exist to provide quality treatment for those patients committed to them." Manual at 17-19. To avoid liability in actions for violations of patients' rights, physicians must show that they have acted in "good faith" in "compliance with" the manual. *Manual* at 3.

[100] The modern trend is for states to provide, by statute, that treatment is one of the "rights" of patients, and to further provide a statutory right to sue for damages whenever that right, or any right, is abridged. *E.g.*, Ga. Code Ann. (1971), §§ 88-502.3 and 88.502.18; Ariz. Leg. Serv. (1973) (Ch. 185) §§ 36-518 and 36-523; and Conn. Gen. Stat. Ann. (Supp. 1974) §§ 17-206c and 17-206h. *See also*, D.C. Code Ann. §§ 21-562 and 21-591 (1973), which provides criminal penalties for persons who deny patients' rights, including the right to treatment.

posed Instruction No. 4.[101] During the chambers discussion of that instruction, the court suggested adding the words "during such periods of time that he refused such treatment." T 11/28/72 at 6. Petitioner's attorney agreed: "Yes, I think that is appropriate." *Id.* The charge as given read as follows (T Oral Charge 11/28/72 at 11-12):

> "You are instructed that if Plaintiff through his own actions contributed to the withholding of a particular form of treatment, that Plaintiff is not entitled to collect compensation from the Defendants for the failure to give such treatment during the particular period or periods Plaintiff refused such treatment."

The only portion of the instruction that petitioner did not either propose or explicitly accept was the phrase "a particular form of" which, for present purposes, seems immaterial.

Furthermore, petitioner did not raise, brief or argue this "waiver" or "refusal of treatment" point on appeal.[102] The point was raised on appeal by his co-defendant Gumanis, but as the Court of Appeals noted, even Gumanis did not at trial or on appeal object to the instruction. 493 F.2d at 531. Thus, there is no legal issue respecting petitioner's waiver argument properly before this Court. After a review of the sufficiency of the evidence, the United States Court of Appeals found "no reason to believe that either the verdict or the award of damages was based upon the failure to give Donaldson those forms of treatment he refused." 493 F.2d at 531. Accordingly, there is simply nothing left on the waiver issue for this Court to review.[103]

[101] The instruction, as initially proposed, provided: "You are instructed that if plaintiff through his own actions contributed to the withholding of treatment, that plaintiff is not entitled to collect compensation from defendants for failure to give such treatment."

[102] In the Reply Brief for Petitioner at 2, petitioner concedes that the waiver point was only "raised on appeal by the co-defendant Gumanis. . . ."

[103] Furthermore, the jury could have found that respondent never in fact did refuse either electro-convulsive therapy or drug therapy, which were the only two forms of therapy petitioner ever alleged that respondent refused. Petitioner's contention that respondent "consistently" and "continually" refused shock therapy (Petr. Brief at 5-6, 49, 50), finds no support in the record. In fact, there is no evidence in the record that respondent ever actually "refused shock therapy." It is true, as petitioner points out, that at the time of his admission, respondent "requested" that no shock therapy be administered. (Petr. Brief at 5), but a request that shock not be administered is different from a refusal. Dr. C. H. Adair, who had procured the consent of respondent's parents to shock therapy should it be necessary (H at 163), testified that he had no recollection that respondent had ever "refused" shock therapy. A at 145; T 11/27/72 at 138. Dr. Adair further testified that ". . . I don't think it [shock treatment] was particularly indicated . . . I probably wouldn't have given it to him anyhow, whether he refused it or not, under any conditions." A at 145; T 11/27/72 at 138.

There was further evidence from which the jury could have concluded that petitioner never believed drugs were either necessary or appropriate for respondent. Petitioner never tried to persuade respondent of the value of drugs, and never told respondent what he thought medication would do to improve respondent's condition. A at 52; T 11/22/72 at 257. When respondent was transferred to the care of Dr. Hanenson late in his stay at Florida State Hospital, Dr. Hanenson actually gave respondent medication but discontinued it after about two weeks. A at 202(b)(i); H at 70. From this and other evidence in the record (A at 52; T 11/22/72 at 257), the jury could have concluded that respondent did not actually refuse drugs, and that in 1967 he even accepted them when, for the first time, they were actually prescribed, but that drugs apparently had little or not effect on his mental condition, and were, therefore, discontinued.

CONCLUSION

For the reasons set forth above, the judgment of the Court of Appeals for the Fifth Circuit should be affirmed.

Respectfully submitted,

BRUCE J. ENNIS, JR.
84 Fifth Avenue
New York, N.Y. 10011

EUGENE DUBOSE, JR.
357 East Chicago Avenue
Chicago, Illinois 60611

BENJAMIN W. HEINEMAN, JR.
PAUL R. FRIEDMAN
MENTAL HEALTH LAW PROJECT
1751 N Street, N.W.
Washington, D.C. 20036

Attorneys for Respondent

Of Counsel:

GEORGE DEAN
Box 248
Destin, Florida 37541

MORTON BIRNBAUM
225 Tompkins Avenue
Brooklyn, N.Y. 11216

January 4, 1975

Supreme Court, U. S.
FILED
DEC 9 1974
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D.,

Petitioner,

vs.

KENNETH DONALDSON,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR STATE OF NEW JERSEY AS AMICUS CURIAE

WILLIAM F. HYLAND,
Attorney General of New Jersey,
Attorney for State of New Jersey as Amicus Curiae,
State House Annex,
Trenton, New Jersey, 08625.

STEPHEN SKILLMAN,
Assistant Attorney General,
Of Counsel.

JOSEPH T. MALONEY,
Deputy Attorney General,
On the Brief.

Adams Press Corp., 11 Commerce Street, Newark, N. J.—Market 3-8611-12

TABLE OF CONTENTS

	PAGE
INTEREST OF THE AMICUS	1
ARGUMENT—State-employed psychiatrists, who reasonably attempt to provide patients of a State institution with medical care within the scope of available State facilities and finances, should not be held personally liable for money damages in a patient's civil rights action based upon a newly recognized constitutional right to treatment	6
CONCLUSION	13

Cases Cited

Allgor v. N. J. State Hospital, 80 N. J. Eq. 386 (Chan. 1912)	4
Bolton v. Harris, 395 F. 2d 642 (D. C. Cir. 1968)	4
Burnham v. Department of Public Health of the State of Georgia, 349 F. Supp. 1335 (N. D. Ga. 1974)	7
City of Kenosha, Wisc. v. Bruno, 412 U. S. 507 (1973)	9
Dandridge v. Williams, 397 U. S. 471 (1970)	3, 6
Dixon v. Jacobs, 427 F. 2d 589 (D. C. Cir. 1970)	7
Duhne v. State of New Jersey, 251 U. S. 311 (1920)	9
Edelman v. Jordan, —— U. S. ——, 94 S. Ct. 1347, 39 L. Ed. 2d 662 (1974)	9
Ex Parte Perry, 137 N. J. Eq. 161 (Chan. 1945)	4
Gittlemacher v. Prasse, 428 F. 2d 1 (3rd Cir. 1970)	10
Great Northern Life Insurance Co. v. Read, 322 U. S. 47 (1943)	9

PAGE

Heukelekian, In re, 24 N. J. Super. 407 (App. Div. 1953) 4

Isenberg v. Prasse, 433 F. 2d 449 (3rd Cir. 1970)..... 10

Jefferson v. Hackney, 406 U. S. 535 (1972)..... 3, 6

Kirstein v. Rectors and Visitors of University of Va., 309 F. Supp. 184 (E. D. Va. 1970)..... 12

Lindsey v. Normet, 405 U. S. 56 (1972)..... 7

McKinney v. DeBord, 324 F. Supp. 928 (E. D. Cal. 1970) 12

Monroe v. Pape, 365 U. S. 167 (1961)..... 9

Nason v. Superintendent of Bridgewater State Hospita, 353 Mass. 604, 233 N. E. 2d 908 (Sup. Ct. 1968) 7, 8

New York State Association for Retarded Children, Inc. v. Rockefeller, 357 F. Supp. 752 (E. D. N. Y. 1973) 7

Pierson v. Ray, 386 U. S. 547 (1967)..... 10, 12

Rouse v. Cameron, 373 F. 2d 451 (D. C. Cir. 1967).... 7, 10

R.R., In re, 140 N. J. Eq. 371 (Chan. 1947)..... 4

San Antonio Independent School District v. Rodriguez, 411 U. S. 1 (1973)..... 3, 6

Scheuer v. Rhodes, —— U. S. ——, 34 S. Ct. ——, 40 L. Ed. 2d 90 (1974)..... 10

Singer v. State, 63 N. J. 319 (1973)..... 3

Smith v. Spina, 477 F. 2d 1140 (3rd Cir. 1973)..... 9

State v. Carter, 64 N. J. 382 (1974)..... 3

Tribby v. Cameron, 379 F. 2d 104 (D. C. Cir. 1967).... 8

Westberry v. Fisher, 309 F. Supp. 12 (D. Me. 1970).. 12

PAGE

United States Constitution Cited

Eleventh Amendment 9

Fourteenth Amendment 7

Statutes Cited

Civil Rights Act 9, 13

N.J.S.A. 30:4-23 4

N.J.S.A. 30:4-24.1 3

N.J.S.A. 30:4-24.2 3

42 U.S.C.A.:

Sec. 1983 ..... 7, 9, 10

Rule Cited

Rule 42 1

Other Authorities Cited

Friedman, M.D., and Kaplan, M.D., Comprehensive Textbook of Psychiatry (1967):

p. 1436 11

80 Harv. L. Rev. (1967):

898, 900 11

Note, Civil Restraint, Mental Illness and the Right to Treatment, 77 Yale L. Rev. (1969):

87 11

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner,

vs.

KENNETH DONALDSON,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF FOR STATE OF NEW JERSEY AS AMICUS CURIAE

Interest of the Amicus

The State of New Jersey, acting by and through its Attorney General, respectfully submits this brief as amicus curiae, pursuant to Rule 42 of the Revised Rules of the Supreme Court of the United States, because of its importance to the State in the operation of its state resi-

denial facilities for the mentally ill and the mentally retarded.

The State of New Jersey has been engaged in the residential treatment of mental disorders for many years. Thus, of the more than 30 mental institutions established or expanded throughout the world by Dorthea Dix, the famed pioneer in the mental health field, the first state hospital in the United States to be built entirely as a result of her efforts was the Trenton State Hospital, built in 1848. As in most states, the New Jersey in-patient psychiatric facilities are financed by state appropriations, staffed by state civil service employees, and operated for the care and treatment of the menally ill who are admitted thereto without regard to their ability to pay or their state domicile or residence. The resident population of the 20 New Jersey facilities for the mentally ill and mentally retarded is approximately 18,700 persons. It is estimated that perhaps 60% of the mentally ill patients were committed involuntarily.

The Division of Mental Health and Hospitals of the New Jersey Department of Institutions and Agencies provides professional and administrative leadership in the planning and programming of mental health facilities for the State. Its present role is a highly complex one and includes, consistent with modern medical aims, stimulating the development of non-State operated diagnostic and treatment facilities, and co-ordinating the planning of all possible resources for the most effective utilization of manpower and financing available. The traditional function of the State in the operation of large inpatient psychiatric hospitals, however, remains a major undertaking of the State, as it is for most states. New Jersey State appropriations for the 1974 fiscal year for operating the seven state mental hospitals are approximately $78,000,000.

An additional amount of approximately $19,000,000 is appropriated for state aid for the seven county mental hospitals.

In 1965, the State Legislature enacted a statutory right to treatment for the mentally ill and the mentally retarded, N.J.S.A. 30:4-24.1, with a remedy in support of the right of habeas corpus. N.J.S.A. 30:4-24.2. See *State* v. *Carter*, 64 N. J. 382, 393 (1974); *Singer* v. *State*, 63 N. J. 319 (1973). When a person is admitted to a state hospital for the mentally ill in New Jersey, he is entitled, pursuant to N.J.S.A. 30:4-24.1, to receive treatment as follows:

> "Every individual who is mentally ill or mentally retarded shall be entitled to humane care and treatment and, *to the extent that facilities, equipment and personnel are available,* to medical care and other professional services in accordance with the highest standards."

Thus, the right of a patient to treatment is necessarily qualified by the legislative recognition that the resources of the state are, of course, limited. While the state mental hospitals have a duty to treat their patients to the extent that their facilities, equipment and personnel are available, their very operations involve difficult questions of the allocation of the State's resources, which the Court has recognized in other areas to be matters uniquely within the province of the Legislature to determine. See e.g., *Dandridge* v. *Williams*, 397 U. S. 471 (1970); *Jefferson* v. *Hackney*, 406 U. S. 535 (1972); *San Antonio Independent School District* v. *Rodridguez*, 411 U. S. 1 (1973).

In enacting the 1965 Act, the New Jersey Legislature therein defined "mental illness" as a mental disease to such an extent that a person so afflicted requires care and

treatment "for his own welfare, or the welfare of others, or of the community." N.J.S.A. 30:4-23. It thereby adopted the traditional decisional definition of persons who may be involuntarily restrained. *Bolton* v. *Harris,* 395 F. 2d 642 (D. C. Cir. 1968). Thus, persons suffering from mental illness may not be involuntarily committed merely because they may "benefit" from hospitalization, or even when they may require it unless their needs are such that their commitment is necessary for their own welfare or the welfare of others or the community.

New Jersey has also long had judicial procedures whereby any patient of a mental hospital who claimed his confinement was improper could obtain meaningful judicial review. See *e.g., Allgor* v. *N. J. State Hospital,* 80 N. J. Eq. 386 (Chan. 1912); *Ex Parte Perry,* 137 N. J. Eq. 161 (Chan. 1945); *In re R.R.,* 140 N. J. Eq. 371 (Chan. 1947); *In re Heukelekian,* 24 N. J. Super. 407 (App. Div. 1953). Recently, the state civil commitment procedures were reexamined by the Chief Justice of the Supreme Court of New Jersey who on November 12, 1974 issued new policies and procedures of judicial administration to substantially strengthen the protections afforded involuntary admittees. These measures are designed to accelerate the time period within which final commitment hearings must be held, to improve the written notice procedures, to restrict adjournments of final hearings, and to require periodic judicial review of all patients involuntarily committed.

The State of New Jersey thus wholeheartedly endorses the principle that the mentally ill have a right to treatment. Indeed, its Legislature has provided for the aforesaid statutory right to such care, in accordance with the highest accepted standards, and to the extent that facilities, equipment and personnel are available, and proceed-

ures whereby the mentally ill may seek release on the grounds that continued confinement would not be appropriate. Nevertheless, since there is substantial disagreement as to what constitutes "care and treatment" of the mentally ill, and given the serious problems of revenue-raising and the allocation of limited governmental resources among numerous vital state services, the State of New Jersey, as amicus curiae, has a vital interest in seeking a reversal of the damages aspect of the decision below. The recognition of a constitutional right to treatment, not as a basis for the traditional remedy of release from institutionalization, but as a basis for a retroactive money damages award against state psychiatrists personally, grounded largely on a state's limited fiscal, administrative and manpower resources, will not advance any state's efforts to improve its mental health program. Rather, funds which, but for the decision, would have been earmarked for the development of staff, programs or physical plant may, by necessity, be thereby diverted to finance the legal defense or indemnification of overworked and modestly paid state hospital personnel who will be suable by former patients for violation of a heretofore undefined "right to treatment". The State of New Jersey, therefore, strongly urges the Court to reverse the decision of the court below.

ARGUMENT

State-employed psychiatrists, who reasonably attempt to provide patients of a State institution with medical care within the scope of available State facilities and finances, should not be held personally liable for money damages in a patient's civil rights action based upon a newly recognized constitutional right to treatment.

The Court has consistently recognized that there are intractable economic, social and even philosophical problems presented in social legislation, and has specifically held that "the Constitution does not empower the Court to second-guess state officials charged with the responsibility of allocating limited public funds among the myriad of potential recipients". See e.g., in the welfare area, *Dandridge* v. *Williams, supra; Jefferson* v. *Hackney, supra;* and in the financing and managing of a statewide public school system, *San Antonio Independent School District* v. *Rodriguez, supra.* The same principles should also be applicable to the financing and managing of state mental hospitals.

In this case the decision below admittedly did not scrutinize Florida's entire program of mental health residential facilities. Nevertheless, as a threshold consideration, it should be viewed in terms of the real root cause of the paucity of sufficient personnel, finances and resources at the Florida State Hospital which rendered it impossible for the physicians to have afforded a level of treatment to Donaldson which the court would later find acceptable. It cannot be seriously doubted that only the Florida Legislature, and not the attending physicians, had determined whether the State should operate residential facilities for the mentally ill at all, and to what extent it should exercise

its taxation powers and expend its limited revenues among this one of many social ills. Even assuming that the present system of financing mental hospitals in many states leaves much to be desired it should be remembered that ". . . the Constitution does not provide judicial remedies for every social and economic ill". *Lindsey* v. *Normet,* 405 U. S. 56 (1972). Therefore, the lower court decision could drastically impede a state's ability to find, recruit and retain the services of essential medical, para-medical and administrative personnel for mental hospitals, once it is mandated that they may hereafter be held personally liable for a failure to treat a former patient notwithstanding the fact that the underlying cause is, in reality, a lack of state-funded resources.

The court below found that a former patient involuntarily committed to a state hospital had a right to treatment based on the Due Process Clause of the Fourteenth Amendment. Cf., *New York State Association for Retarded Children, Inc.* v. *Rockefeller,* 357 F. Supp 752 (E. D. N. Y. 1973) and *Burnham* v. *Department of Public Health of the State of Georgia,* 349 F. Supp. 1335 (N. D. Ga. 1974). The striking point of departure of the decision from previous cases dealing with a right to treatment, however, lies in the fact that it enunciates such a new constitutional right while simultaneously holding that it forms the basis for a personal money damage award under 42 U.S.C.A. §1983 against a state employee. Heretofore, the courts which have examined the problem and found a right to treatment, whether on constitutional or statutory grounds, have not entered a judgment for money damages, but have vindicated the right by the traditional remedy of release under habeas corpus. See e.g., *Rouse* v. *Cameron,* 373 F. 2d 451 (D. C. Cir. 1967); *Dixon* v. *Jacobs,* 427 F. 2d 589 (D. C. Cir. 1970); and *Nason* v. *Superintendent*

of Bridgewater State Hospital, 353 Mass. 604, 233 N. E. 2d 908 (Sup. Ct. 1968). These cases recognize that release by habeas corpus will not only prevent indeterminate confinement without treatment, but also that when, through no fault of the institution or the physicians, treatment may not be available, release is necessary because the officials will be unable to guarantee the patient's rights within the institution. They further recognize that actual outright release may frequently not be the proper remedy, and that conditional release may be in order, or that an order permitting the hospital a reasonable opportunity to initiate treatment may be appropriate. See, *Tribby* v. *Cameron*, 379 F. 2d 104 (D. C. Cir. 1967); and *Nason* v. *Superintendent of Bridgewater Hospital*, supra.

The unfairness in the present case is that prior to the imposition of liability herein, and unlike the earlier right to treatment cases, there was no initial court order permitting the hospital or physicians some reasonable opportunity to initiate treatment, or ordering the unconditional or conditional release of respondent after opportunity for treatment was exhausted or treatment was deemed inappropriate. Neither was there any preliminary order that the state hospital's treatment programs be evaluated or upgraded. Instead, the court enunciated the constitutional right, applied it to a patient no longer hospitalized, and simultaneously upheld a monetary award for violation of that right.

A further serious concern raised by this case is the ironic imposition of damages upon the state physicians personally in view of the fact that the State itself could not be so held liable even though insufficient state funding was the underlying cause of inability to meaningfully treat respondent. A state is immune from federal actions

against it by citizens of another state without its consent, and is equally immune from such actions by its own citizens. *Duhne* v. *State of New Jersey*, 251 U. S. 311 (1920). The Eleventh Amendment bars suits not only against a state when it is the named party but also when it is the party in fact in an action seeking damages from the public treasury. *Great Northern Life Insurance Co.* v. *Read*, 322 U. S. 47 (1943). In *Edelman* v. *Jordan*, —— U. S. ——, 94 S. Ct. 1347, 39 L. Ed. 2d 662 (1974), the Court recently re-enunciated the rule that a federal court's remedial power may not include a retroactive award which requires the payment of funds from the state treasury. Additionally, a municipal corporation cannot be a "person" within the ambit of 42 U.S.C.A. §1983. *Monroe* v. *Pape*, 365 U. S. 167 (1961), whether the remedy sought is damages or equitable relief, *City of Kenosha, Wisc.* v. *Bruno*, 412 U. S. 507 (1973). Thus, even if inadequate state funding prevents state psychiatrists from affording adequate treatment to patients in state institutions, neither the state nor any of its agencies can be held liable for same nor even be the subject of a suit under the Civil Rights Act. To transpose liability for such inadequacies to state psychiatrists, who lack control or jurisdiction over such fiscal determinations, would be manifestly unfair.

As the Court noted in *Smith* v. *Spina*, 477 F. 2d 1140, 1143 (3rd Cir. 1973), the Civil Rights Act is not a general tort statute:

> "It is, of course, fundamental that the Civil Rights Act permits recovery for only 'deprivations of any rights, privileges, or immunities secured by the [federal] Constitution and [federal] laws'. We have recently said: 'It becomes important to delineate that conduct which is actionable in state courts as a tort, and that which is actionable in federal courts under §1983."

These principles have been applied to actions by state prison inmates under the Civil Rights Act wherein they have sued state officials for alleged improper or inadequate medical care. See, e.g., *Isenberg* v. *Prasse*, 433 F. 2d 449 (3rd Cir. 1970); *Gittlemacker* v. *Prasse*, 428 F. 2d 1 (3rd Cir. 1970). Similarly, in *Pierson* v. *Ray*, 386 U. S. 547 (1967), the Court held that the defense of "good faith and probable cause" is available to police officers sued under 42 U.S.C.A. §1983 for an alleged false arrest and imprisonment. Recently, the Court indicated that when the conduct of higher officers of the executive branch, as distinguished from local police, are evaluated in such suits, "the inquiry is far more complex since their range of decisions and choices—whether the formulation of policy, of legislation, of budgets, or of day-to-day decisions, is virtually infinite." *Scheuer* v. *Rhodes*, —— U. S. ——, 94 S. Ct. ——, 40 L. Ed. 2d 90 (1974).

While in the instant case the court paid lip-service to allowing the state psychiatrists a "good faith" defense in cases of this kind, by ignoring the evidence that insufficient resources at the state hospital in reality made adequate treatment impossible, it thereby effectively eliminated such a defense. It is also seriously questionable whether there was the sufficient analysis below of the responsibilities of the physicians, the scope of their discretion, and all of the circumstances as they reasonably appeared at the time of the action, as called for by *Scheuer* v. *Rhodes*, *supra*. There is wide professional disagreement not only as to what constitutes or causes mental illness but even on the methods of how to treat it. No one can reasonably disagree that psychiatry is an area of medical science still plagued with uncertainty. See *Rouse* v. *Cameron*, *supra*. Medical science has not succeeded yet in finding a cure for every disease and this is just as true

of mental diseases as cancer. Even if all patients are "treatable," which Judge Bazelon has stated may be a legal fiction (80 Harv. L. Rev. 898, 900 (1967)), still there is, and could be, no rule demanding that a hospital cure all cases according to a specific timetable. No one can demonstrate with assurance that increased resources would accomplish a cure or substantial improvement in respondent's condition. For example, assume the Hospital had the financial resources to assign an expert psychiatrist solely to treat him. Would this guarantee his cure or substantial improvement? No. No one has yet shown convincingly that schizophrenia, with which respondent was afflicted, is curable by a prolonged one-to-one relationship with a therapist. The *Comprehensive Textbook of Psychiatry* by A. M. Friedman, M.D., and Harold I. Kaplan, M.D. (1967), p. 1436, states with authority about such cases that:

> "Outcome seems to be more a function of the disorder than of the type or amount of treatment."

Thus, improvement of the patient is not a reliable index of whether he is being treated, at least within reasonable limits. Studies have shown that for some disorders there is a spontaneous remission rate as high as 20 per cent without any treatment, and on the other hand, some patients will not recover no matter what treatment is attempted. See "Note," *Civil Restraint, Mental Illness and the Right to Treatment*, 77 Yale L. Rev. 87 (1969).

It is significant that respondent had, prior to this case, brought fifteen habeas corpus cases in the state and federal courts, all of which were unsuccessful. Were not the physicians acting reasonably when they believed that the court dispositions of respondent's multiple petitions indicated that his confinement and treatment were not improper? Further, no one has ever suggested that they

thwarted respondent's many applications for release by habeas corpus or otherwise impeded his access to the courts. It should also be considered that there are no facts herein tending to indicate that the respondent's treatment was substantially different or inferior to that rendered others based on extraordinary grounds, *e.g.*, racial or religious discrimination, or cruelty. Neither were there any facts indicating the physicians singled out respondent for inferior treatment intentionally, or were motivated by malice or ill-will. For these reasons it seems abundantly clear that the scope of the defense of good faith, to which the state physicians should have been entitled, was misapplied. The findings of the District Court point to the conclusion that the Florida state physicians did a poor job in caring for Donaldson. However, the imposition of monetary liability upon a physician under the Civil Rights Act simply because he has failed to do a proper job would be an unwarranted and improper extension of the terms of that Act.

Finally, in *Pierson*, the Court also held that "a police officer is not charged with predicting the future course of constitutional law", 386 U. S. at 557. Since *Pierson*, the rule has been applied in a variety of factual contexts to avoid the harsh imposition of liability retroactively when the courts are enunciating new constitutional rules. See e.g., *McKinney* v. *DeBord*, 324 F. Supp. 928 (E. D. Cal. 1970) (prison officials); *Westberry* v. *Fisher*, 309 F. Supp. 12 (D. Me. 1970) (welfare officials); and *Kirstein* v. *Rectors and Visitors of University of Va.*, 309 F. Supp. 184 (E. D. Va. 1970) (university officials). No apparent persuasive reason exists why the same rule should not also be applied to state psychiatrists sued in a Civil Rights action by a former patient wherein the court is imposing a constitutional right to treatment in a case of first impression, so as to avoid the imposition of retroactive liability in such an unfair manner.

The conflict between social and individual interests existing in this case can be fully reconciled only by public allocation of larger sums of money to mental hospitals, which obviously is a fundamentally political question. While there may be no legitimate state interest in the permanent detention of the mentally ill unless they are dangerous to society, the recognition of a new constitutional right to treatment at the simultaneous expense of a state employee is not an appropriate application of the Civil Rights Act.

CONCLUSION

For the foregoing reasons, it is respectfully submitted that the decision below upholding an award of money damages against the state physicians under the Civil Rights Act is erroneous and therefore should be reversed.

Respectfully submitted,

WILLIAM F. HYLAND
Attorney General of New Jersey
Attorney for Amicus Curiae
State of New Jersey

STEPHEN SKILLMAN
Assistant Attorney General
Of Counsel

JOSEPH T. MALONEY
Deputy Attorney General
On the Brief

Supreme Court of the United States

October Term, 1974

No. 74-8

J. B. O'CONNER, M.D.,

Petitioner,

vs.

KENNETH DONALDSON,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF OF STATE OF OHIO AMICUS CURIAE

WILLIAM J. BROWN
Ohio Attorney General

ANDREW J. RUZICHO
BARBARA J. ROUSE
Ohio Assistant Attorneys General
State Office Tower
Columbus, Ohio 43215
Attorneys for the State of Ohio, Amicus Curiae

THE GATES LEGAL PUBLISHING CO., CLEVELAND, OHIO—TEL. (216) 621-5647

TABLE OF CONTENTS

Interest of the Amicus 1

Opinion Below 3

Questions Presented 3

Statement of the Case 3

Argument 3

I. A Person Involuntarily Committed to a State Mental Hospital Has a Constitutional Right to Receive Such Individual Treatment As Will Give Him a Reasonable Opportunity to Be Cured or to Improve His Mental Condition 3

II. The Lower Court's Decision Permitting Monetary Damages Should Be Reversed 6

Conclusion 8

APPENDIX:

Affidavit 9

Comparable Wage Study 11

TABLE OF AUTHORITIES

Cases

Burton v. Reshetylo, 38 Ohio St. 2d 35 (1974) 6
Clarke v. Cady, 358 F. Supp. 1156 (W.D. Wis. 1973) 7
Collins v. Schoonfield, 363 F. Supp. 1152 (D. Md. 1973) 7
Davis v. Watkins, CA 73-205 (N.D. Ohio 1974) 2
Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3239 (Oct. 22, 1974) 5
Edelman v. Jordan, ... U.S. ....., 94 S. Ct. 1347, 39 L. Ed. 2d 662 (1974) 7
Eslinger v. Thomas, 476 F.2d 225 (4th Cir. 1973) 7
Jackson v. Indiana, 406 U.S. 715 (1972) 4, 6, 8
Kirstein v. Rectors and Visitors of University of Virginia, 309 F. Supp. 184 (E.D. Va. 1970) 7
Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972) 6
Millard v. Cameron, 373 F.2d 468 (D.C. Cir. 1966) 6
Miller v. Overholser, 206 F.2d 415 (D.C. Cir. 1953) 6
Monroe v. Pape, 365 U.S. 167 (1961) 7
Morales v. Turman, 364 F. Supp. 166 (E.D. Texas 1973) 6
Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974) 5
Pierson v. Ray, 386 U.S. 547 (1967) 7
Robinson v. California, 370 U.S. 660 (1962) 4
Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) 5
Skinner v. Spellman, 480 F.2d 539 (4th Cir. 1973) 7
Smith v. Spina, 477 F.2d 1140 (3rd Cir. 1973) 7
Stachulak v. Coughlin, 364 F. Supp. 686 (N.D. Ill. 1973) 6
United States ex rel. Schuster v. Herold, 410 F.2d 1071 (2d Cir. 1969), *cert. denied*, 396 U.S. 847 (1969) 6
Welsch v. Likins, 373 F. Supp. 487 (D. Minn. 1974) 6

Westberry v. Fisher, 309 F. Supp. 12 (D. Me. 1970) 7
Wyatt v. Aderholt, No. 72-2634 (5th Cir. 1974) 4, 5
Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), *on submission on proposed standards*, 334 F. Supp. 1341, *enforced*, 344 F. Supp. 373, *appeal docket sub nom. Wyatt v. Aderholt*, No. 72-2634 (5th Cir. 1974) 1, 4

Text

Quarterly Journal of the National Association of Mental Health, Volume 56, No. 4, Fall 1972 1

Supreme Court of the United States

October Term, 1974

No. 74-8

J. B. O'CONNER, M.D.,
Petitioner,

vs.

KENNETH DONALDSON,
Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

BRIEF OF STATE OF OHIO AMICUS CURIAE

INTEREST OF THE AMICUS

The State of Ohio has a direct and immediate interest in the recognition of a constitutional right to treatment. Confined in 28 Ohio facilities for the mentally ill and mentally retarded are approximately 18,350 persons,[1] approximately one-half of whom were committed involuntarily. The State believes that each involuntarily committed patient has "a constitutional right to receive such individual treatment as will give each of them a realistic opportunity to be cured or to improve his or her mental condition." *Wyatt v. Stickney*, 325 F. Supp. 781, 784 (M.D. Ala. 1971), *on submission on proposed standards*, 334 F. Supp. 1341, *enforced*, 344 F. Supp. 373, *appeal docket sub nom. Wyatt v. Aderholt*, No. 72-2634 (5th Cir. 1974).

1. According to research published in the *Quarterly Journal of the National Association of Mental Health*, Volume 56, No. 4, Fall 1972, this year 1 out of every 10 Americans will suffer some form of mental illness severe enough to require hospitalization.

Ohio demonstrated its firm commitment to mental health care when it admitted the existence of such a right in its Answer filed in a suit involving persons committed to a state facility for the criminally insane.[2] Any decision concerning the constitutional right to treatment will affect the citizens of Ohio and the state officials responsible for delivering mental health services to the people.

In Ohio, many deficiencies still exist in the delivery of mental health services. There is certainly a lack of a sufficient number of qualified staff. Ohio has undertaken an active recruitment program in order to attract qualified mental health professionals including psychiatrists. Presently 96 fulltime board eligible psychiatrists and 22 fulltime board certified psychiatrists service 26 institutions in Ohio. One of the major problems in recruitment of qualified staff to state service is that the salary scale is not competitive with the scale in private practice. See Appendix. Since this case involves the issue of the awarding of monetary damages against physicians who work in state institutions, this court's decision will affect Ohio's operation of mental health facilities.

Thus, the State of Ohio, acting by and through the Attorney General of the State, respectfully submits this brief as *amicus curiae* pursuant to Rule 42, of the Revised Rules of the Supreme Court of the United States, requesting an affirmance in part and reversal in part of the lower court's decision.

---

2. *Davis v. Watkins*, CA 73-205 (N.D. Ohio, 1974). This case, a class action filed against state officials, alleged, *inter alia*, a constitutional right to treatment for patients involuntarily committed for the purpose of treatment. On September 9, 1974, United States District Judge Nicholas Walinski recognized the constitutional right to treatment and defined the parameters of such a right. The order is comprehensive and will have significant ramifications for the treatment of all persons confined in Ohio mental health facilities.

OPINION BELOW

The opinion of the United States Court of Appeals for the Fifth Circuit is reported at 493 F.2d 507.

QUESTIONS PRESENTED

1. Whether a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition.

2. Whether a state-employed physician in the absence of an enunciated constitutional right to treatment can be held personally liable for monetary damages.

STATEMENT OF CASE

The State of Ohio adopts the summary of the facts of record as found in the opinion of the court below, 493 F.2d 507 at 510-515.

ARGUMENT

I. A PERSON INVOLUNTARILY COMMITTED TO A STATE MENTAL HOSPITAL HAS A CONSTITUTIONAL RIGHT TO RECEIVE SUCH INDIVIDUAL TREATMENT AS WILL GIVE HIM A REASONABLE OPPORTUNITY TO BE CURED OR TO IMPROVE HIS MENTAL CONDITION

This court should affirm the lower court's holding that the Constitution guarantees a person involuntarily

committed to a state hospital a right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition. There are two significant cases decided by this court which shed substantial light upon the existence of a constitutional right to treatment.

In *Robinson v. California*, 370 U.S. 660 (1962), a California statute imposing a ninety-day prison sentence on narcotics addicts was struck down as contrary to the proscriptions of the Eighth Amendment. The Court held that a person would not be punished for an illness, a condition or a "status" from which he could not voluntarily extricate himself. Finding addiction to be an illness, the Court suggested that a statute making the condition or "status" of mental illness a criminal offense punishable by imprisonment without treatment would meet the same determination of unconstitutionality. This principle applies with equal force to a person afflicted with mental illness, for to recognize the malady and fail to provide the necessary opportunity for treatment when that is the purpose of confinement "violates the very fundamentals of due process." *Wyatt v. Stickney, supra,* at 785.

In *Jackson v. Indiana*, 406 U.S. 715 (1972), this Court examined the case of a criminal defendant indefinitely committed solely on account of his incompetency to stand trial and found that "due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." It is just such a mandate which the State of Ohio is following in recognizing that the *quid pro quo* for "therapeutic" involuntary confinement is treatment.

The Court of Appeals for the Fifth Circuit recently decided *Wyatt v. Aderholt*, No. 72-2634 (Nov. 8, 1974)

and held that there is a constitutional right to treatment for persons committed to state mental institutions. Citing their decision in *Donaldson* the Fifth Circuit found the basis for the right in the Due Process Clause of the Fourteenth Amendment which mandated that in cases of civil commitment it is necessary for mental hospitals to provide "rehabilitative treatment or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary." *Donaldson v. O'Connor*, 493 F.2d 507, 522 (5th Cir. 1974), *cert. granted*, 43 U.S.L.W. 3239 (Oct. 22, 1974).

It should be noted that the court in both *Donaldson* and *Wyatt* found that standards of care and treatment were not elusive. With the assistance of experts and the parties themselves, courts can articulate standards. Indeed the standards in the *Wyatt* case were not challenged on appeal by the state of Alabama. *Wyatt v. Aderholt, supra*, n. 10.

Other federal courts have evolved standards of care and constitutional safeguards for persons confined in various state institutions and are persuasive in sustaining a right to treatment for involuntarily committed persons. In *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966), the Court of Appeals for the District of Columbia upheld a right to treatment on statutory grounds but *in dicta* emphasized that the absence of treatment might raise the specter of possible constitutional violations.

Other institutions have come under similar scrutiny. With respect to training schools for juveniles, courts have applied the theory that commitment without treatment becomes punishment for "status" in violation of the Eighth Amendment. See *Nelson v. Heyne*, 491 F.2d 352 (7th Cir. 1974), a medium security institution for juveniles, approximately one-third of whom are non-criminal of-

fenders; *Martarella v. Kelley*, 349 F. Supp. 575 (S.D. N.Y. 1972) juveniles classified as "Persons in Need of Supervision" (PINS); *Morales v. Turman*, 364 F. Supp. 166 (E.D. Texas 1973), where the Court found a constitutional right to treatment for juveniles adjudicated delinquent and involuntarily committed. *See also Millard v. Cameron*, 373 F.2d 468 (D.C. Cir. 1966); *Miller v. Overholser*, 206 F.2d 415 (D.C. Cir. 1953); and *United States ex rel. Schuster v. Herold*, 410 F.2d 1071 (2d Cir. 1969), *cert. denied*, 396 U.S. 847 (1969).

Two district courts have enunciated a right to treatment for civilly committed mentally ill and mentally retarded persons. *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973), right to treatment for the mentally ill; and *Welsch v. Likins*, 373 F. Supp. 487 (D. Minn. 1974), right to treatment for the mentally retarded.

II. THE LOWER COURT'S DECISION PERMITTING MONETARY DAMAGES SHOULD BE REVERSED

The lower court's decision awarding monetary damages because of a violation of the constitutional right to treatment should be reversed. The teachings of *Jackson v. Indiana*, *supra*, and a finding of a constitutional right to treatment should either reduce patient populations in state mental health facilities[3] or cause state legislators to appropriate additional monies for proper mental health care, or both. The finding of a constitutional right to treatment should act as a catalyst for state administrators and legislators in dealing with the problems of providing adequate mental health care. Upon such a finding, it should become unnecessary for courts to hold physicians personally liable for damages except under the most extreme circumstances.

3. See *Burton v. Reshetylo*, 38 Ohio St. 2d 35 (1974).

At the time this case was brought, no constitutional right to treatment had been enunciated by this Court. On the facts of this case, to hold that state employed physicians who are working in less then desirable conditions, are liable in monetary damages, for a failure to provide treatment pursuant to a right not yet enunciated by this Court, is "to hold public officials liable for acts that become unconstitutional *ex post facto*. . ." *Kirstein v. Rectors and Visitors of University of Virginia*, 309 F. Supp. 184 (E.D. Va. 1970). This Court recognized this principle in *Pierson v. Ray*, 386 U.S. 547, 577 (1967) when it stated that a public official cannot be charged with "predicting the future course of constitutional law." See also *Westberry v. Fisher*, 309 F. Supp. 12 (D. Me. 1970). Of course, such monetary damages cannot be awarded against the state treasury. *Edelman v. Jordon*, ... U.S. ....., 94 S. Ct. 1347, 39 L. Ed. 2d 662 (1974); cf. *Monroe v. Pape*, 365 U.S. 167 (1961).[4]

However, the State of Ohio would argue that upon this Court finding a constitutional right to treatment and defining the parameters of the right, any physician who *in futuro* would intentionally and in bad faith provide inadequate or inhumane treatment to a patient in violation of the constitutional right may be held liable for monetary damages. *Pierson v. Ray*, *supra*; *Eslinger v. Thomas*, 476 F.2d 225 (4th Cir. 1973); *Skinner v. Spellman*, 480 F.2d 539 (4th Cir. 1973); *Westberry v. Fisher*, *supra*; *Clarke v. Cady*, 358 F. Supp. 1156 (W.D. Wis. 1973); *Collins v. Schoonfield*, 363 F. Supp. 1152 (D. Md. 1973); *Kirstein v. Rector and Visitors of University of Virginia*, *supra*. To hold otherwise would further affect the State of Ohio's

4. Our position is based upon the statute involved in this case, 42 U.S.C. §1983. The patient may have a state cause of action for damages which would not involve any theory based upon a federal constitutional right to treatment. Cf. *Smith v. Spina*, 477 F.2d 1140 (3rd Cir. 1973).

recruitment efforts of qualified physicians, an already insurmountable problem. Physicians may retreat to the private sector rather than run the risk of public employment. See affidavit of Mr. William Davis, Acting Director, Ohio Department of Mental Health and Mental Retardation attached hereto as an Appendix.

CONCLUSION

A constitutional right to treatment is compatible with this Court's earlier decision in *Jackson v. Indiana, supra.* The obligations arising from a right to treatment and *Jackson* will go a long way to cease the warehousing of patients in this country so that humane treatment and conditions may exist in mental institutions. The petitioners ought not be saddled with monetary damages because of their failure to foresee the enunciation of a constitutional right to treatment. The State of Ohio respectfully argues for an affirmance in part and reversal in part of the lower court's decision.

Respectfully submitted,

WILLIAM J. BROWN
Ohio Attorney General

ANDREW J. RUZICHO
BARBARA J. ROUSE
Ohio Assistant Attorneys General
State Office Tower
Columbus, Ohio 43215
Attorneys for the State of Ohio, Amicus Curiae

APPENDIX

Affidavit of William Davis

AFFIDAVIT

City of Columbus)
) SS
State of Ohio)

I, William Davis, being duly sworn depose and say:

I am William Davis, Acting Director of Ohio's Department of Mental Health and Mental Retardation. My department has an active recruitment program in effect in order to attract qualified mental health professionals to our state. We particularly have a problem hiring qualified psychiatrists. Presently, we employ 96 fulltime board eligible psychiatrists and 22 fulltime board certified psychiatrists. In addition, there are 16 board eligible and eight board certified psychiatrists working parttime for the state. The above figures include superintendents at each institution and administrators in our central office. These psychiatrists service 26 institutions or centers throughout the state.

Our recruitment efforts include maintaining close liaison with national, state and local professional organizations, advertising in national and state publications, utilizing present psychiatrists to assist us in recruitment of other psychiatrists, and surveying other states for purposes of comparative studies of salaries and prerequisites. I have found that salary ranges for psychiatrists in Ohio are a major factor for the difficulty in recruitment of qualified personnel. I have attached hereto a comparative wage study of six states which my office has compiled. If a

court were to hold psychiatrists personally liable for monetary damages because of a failure to provide adequate treatment due to insufficient state funding, in my opinion such a ruling would adversely affect our recruitment efforts for fulltime psychiatrists in state employment.

Further affiant sayeth not.

/s/ WILLIAM DAVIS

Subscribed and sworn to before me this 31st day of December, 1974.

/s/ MARION R. WOLFE
Notary Public

My commission expires October 30, 1977.

Comparable Wage Study

CIVIL SERVICE PAY (ANNUAL)
(1973-1974)

Ohio Civil Service Classification	Ohio •• 10 Yrs. Min. - Max.	Michigan •• 4 Yrs. Min. - Max.	Minnesota •• 5 Yrs. Min. - Max.	Pennsylania •• 6 Yrs. Min. - Max.	Indiana •• 5 Yrs. Min. - Max.	Illinois •• 5 Yrs. Min. - Max.
Physician 1	15142-20322	22028-26893	17892-23532	22357-24626	22204-28210	26160-32160
Physician 2	18013-24398	23970-29190	20928-25464	24626-27091	—— ——	—— ——
Physician 3	21632-28725	25640-31340	21768-26472	27091-29829	25688-32604	28308-34848
Physician Specialist 3[1•]	23546-28725	25640-31340	20928-25464	25564-28177	28319-36018	28308-34848
Physician Specialist 4[2•]	25459-31117	27373-33512	23000-32000	25564-28177	29650-37845	30732-37848
Physician Specialist 5[3•]	26437-32573	30317-37751	28000-38000	28177-34273	not reported	31215-43439

1• Board Eligible Staff
2• Board Certified Staff
3• Board Certified Administration
••No. of yrs. one may acquire maximum salary in any given classification.

Supreme Court, U. S.
FILED
JAN 6 1975
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner,

v.

KENNETH DONALDSON,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR AMICI CURIAE AMERICAN ASSOCIATION ON MENTAL DEFICIENCY; AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO; AMERICAN ORTHOPSYCHIATRIC ASSOCIATION; AMERICAN PSYCHOLOGICAL ASSOCIATION; JOSEPH P. KENNEDY, JR., FOUNDATION; NATIONAL ASSOCIATION FOR MENTAL HEALTH; NATIONAL ASSOCIATION FOR RETARDED CITIZENS; NATIONAL CENTER FOR LAW AND THE HANDICAPPED; NATIONAL SOCIETY FOR AUTISTIC CHILDREN

(List of counsel on inside cover)

WILSON - EPES PRINTING CO., INC. - RE 7-6002 - WASHINGTON, D. C. 20001

FRANCIS M. SHEA
RALPH J. MOORE, JR.
JOHN TOWNSEND RICH
734 Fifteenth Street, N.W.
Washington, D.C. 20005

Attorneys for Amici Curiae

MARCIA PEARCE BURGDORF
1238 North Eddy Street
South Bend, Indiana 46617

Attorney for the National Center for Law and the Handicapped and the National Association for Retarded Citizens

JAMES F. FITZPATRICK
1229 Nineteenth Street, N.W.
Washington, D.C. 20036

Attorney for the American Psychological Association

KURT W. MELCHIOR
One Embarcadero Center
San Francisco, Calif. 94111

HARRY J. RUBIN
P.O. Box 72
York, Pennsylvania 17405

Attorneys for the National Association for Mental Health

SHERIDAN L. NEIMARK
Munsey Building
Washington, D.C. 20004

Attorney for the National Society for Autistic Children

BEVERLEY ROWAN
1701 K Street, N.W.
Washington, D.C. 20036

Attorney for the Joseph P. Kennedy, Jr., Foundation

A. L. ZWERDLING
1211 Connecticut Avenue, N.W.
Washington, D.C. 20036

General Counsel, American Federation of State, County & Municipal Employees, AFL-CIO

SHEA & GARDNER
734 Fifteenth Street, N.W.
Washington, D.C. 20005

Of Counsel

TABLE OF CONTENTS

	Page
INTEREST OF AMICI CURIAE	2
SUMMARY OF ARGUMENT	3
ARGUMENT	6
I. The Monetary Award Against Petitioner Was Not Improper for Any Legal Reason Generally Applicable to Liability Under § 1983	7
A. The Posture of the Case	7
B. Petitioner Does Not Contend That He is Entitled to Absolute Immunity	11
C. Petitioner Was Not Held Liable for a Failure to Provide Treatment Resulting from Inadequacy of State Resources for Which He Was Not Responsible	13
D. Petitioner's Remaining Claims of Unfairness Present No Important Legal Issue and Are Not Supported by the Record	16
E. Conclusion	21
II. Respondent's Continued Confinement was Unconstitutional Because He Was Not Dangerous or Incompetent and Because He Was Denied His Constitutional Right to Treatment	21
A. Persons Like Respondent Who are Neither Dangerous Nor Incompetent Cannot Constitutionally be Hospitalized Against Their Will, Whether or Not They Are Given Treatment	23
B. Persons Committed for Mental Impairments Have a Constitutional Right to Treatment	31
C. The Right to Treatment is Not Nonjusticiable for Lack of Judicially Manageable Standards	36
D. Conclusion	44
CONCLUSION	45

TABLE OF CITATIONS

Cases: Page

Application of President and Directors of Georgetown College, Inc., 331 F.2d 1000 (D.C. Cir.) (single-judge), *pet'n for rehearing denied*, 331 F.2d 1010, *cert. denied*, 377 U.S. 978 (1964) 26
Beverley's Case, 4 Co. Rep. 123b, 76 Eng. Rep. 1118 (K.B. 1603) 27
Board of Regents v. *Roth*, 408 U.S. 564 (1972) 25
Briscoe v. *Kusper*, 435 F.2d 1046 (7th Cir. 1970) 18
Canterbury v. *Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972) 27
Clarke v. *Cady*, 358 F. Supp. 1156 (W.D. Wis. 1973) 18
Commonwealth v. *Leis*, 355 Mass. 189, 243 N.E.2d 898 (1969) 27
Davy v. *Sullivan*, 354 F. Supp. 1320 (M.D. Ala. 1973) (three-judge court) 36
Dunn v. *Blumstein*, 405 U.S. 330 (1972) 28
Eisenstadt v. *Baird*, 405 U.S. 438 (1972) 24
Eslinger v. *Thomas*, 476 F.2d 225 (4th Cir. 1973) 18
Goldblatt v. *Town of Hempstead*, 369 U.S. 590 (1962) 25
Griswold v. *Connecticut*, 381 U.S. 479 (1965) 24
Humphrey v. *Cady*, 405 U.S. 504 (1972) 24
In re Ballay, 482 F.2d 648 (D.C. Cir. 1973) 24
In re Barker, 2 Johns Ch. 232 (N.Y. 1816) 27
In re Estate of Brooks, 32 Ill. 2d 361, 205 N.E. 2d 435 (1965) 26
In re Gault, 387 U.S. 1 (1967) 36
In re Griffiths, 413 U.S. 717 (1973) 27
Inmates of Boys' Training School v. *Affleck*, 346 F. Supp. 1354 (D.R.I. 1972) 36
Jackson v. *Indiana*, 406 U.S. 715 (1972) 31
Jacobson v. *Mass.*, 197 U.S. 11 (1905) 27
Kesselbrenner v. *Anonymous*, 33 N.Y. 2d 161, 305 N.E. 2d 903, 350 N.Y.S. 2d 889 (1973) 25

TABLE OF CITATIONS—Continued

Page

Lessard v. *Schmidt*, 349 F. Supp. 1078 (E.D. Wis. 1972) (threee-judge court), *vacated & remanded on other grounds*, 414 U.S. 473 (1974) 28
Martarella v. *Kelley*, 349 F. Supp. 575, *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1972) 36
McKinney v. *DeBord*, 324 F. Supp. 928 (E.D. Calif. 1970) 18
Morales v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973) 36
NAACP v. *Alabama*, 357 U.S. 449 (1958) 24
NAACP v. *Button*, 371 U.S. 415 (1963) 24
Nelson v. *Heyne*, 491 F.2d 352 (7th Cir. 1974), *affirming* 355 F. Supp. 451 (N.D. Ind. 1972) 36
New York State Association for Retarded Children, Inc. v. *Rockefeller*, 357 F. Supp. 752 (E.D. N.Y. 1973) 29, 36
Pierson v. *Ray*, 386 U.S. 547 (1967) 11
Powell v. *Texas*, 392 U.S. 514 (1968) 34
Robinson v. *California*, 370 U.S. 660 (1962) 33
Roe v. *Wade*, 410 U.S. 113 (1973) 25
San Antonio Indep. School Dist. v. *Rodriguez*, 411 U.S. 1 (1973) 28
Sas v. *Maryland*, 334 F.2d 506 (4th Cir. 1964) 36
Scheuer v. *Rhodes*, 416 U.S. 232 (1974) 12, 13
Shapiro v. *Thompson*, 394 U.S. 618 (1969) 24
Skinner v. *Spellman*, 480 F.2d 539 (4th Cir. 1972) 18
Stachulak v. *Coughlin*, 364 F.2d 686 (N.D. Ill. 1973) 36
Taylor v. *Perini*, 365 F. Supp. 557 (N.D. Ohio 1972) 18
Tribby v. *Cameron*, 379 F.2d 104 (D.C. Cir. 1966) 42
Welsh v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) 29, 36, 41
Whirl v. *Kern*, 407 F.2d 781 (5th Cir. 1969) 19, 20
Williams v. *Robinson*, 432 F.2d 637 (D.C. Cir. 1970) 43

TABLE OF CITATIONS—Continued

	Page
Winters v. *Miller*, 464 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971)	27
Wisconsin v. *Constantineau*, 400 U.S. 433 (1971)	25
Wyatt v. *Stickney*, 325 F. Supp. 781, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd in part sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974)	*passim*
Constitution, Statutes and Regulations:	
U.S. CONST., Amend. VIII	33-34
U.S. CONST., Amend. XIV	*passim*
R.S. § 1979, 42 U.S.C. § 1983 (1970)	*passim*
27 FLA. STAT. § 394.09 (1955) (repealed July 1, 1972)	18, 31
27 FLA. STAT. § 394.22(11)(a) (1955) (repealed July 1, 1972)	35
39 FED. REG. 2219 (Jan. 17, 1974), *amending* 45 C.F.R. ch. II (Intermediate Care Facility Services)	39
Miscellaneous:	
American Psychiatric Association, *Position Paper on Involuntary Hospitalization of the Mentally Ill*, 310 AMERICAN JOURNAL OF PSYCHIATRY 3 (1973)	39
AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES (1974)	39
American Psychiatric Association Task Force on the Right of Care and Treatment, Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded (December 1974)	39
AMERICAN PSYCHOLOGICAL ASSOCIATION, STANDARDS FOR PROVIDERS OF PSYCHOLOGICAL SERVICES (1974)	39

TABLE OF CITATIONS—Continued

	Page
W. BLACKSTONE, COMMENTARIES *304	27
Developments in the Law—Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190 (1974)	*passim*
FAIRWEATHER ET AL., COMMUNITY LIFE FOR THE MENTALLY ILL—AN ALTERNATIVE TO INSTITUTIONAL CARE (1969) at 10	25
FRAZIER & CARR, INTRODUCTION TO PSYCHOPATHOLOGY (1964) at 224	25
Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L. J. 782 (1969)	42
F. HARPER & F. JAMES, LAW OF TORTS (1956)	20
JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR PSYCHIATRIC FACILITIES (1972)	38
JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, STANDARDS FOR RESIDENTIAL FACILITIES FOR MENTALLY RETARDED (1971)	38
Langsley, et al., *Follow-up Evaluation of Family Crisis Therapy*, 39 AMERICAN JOURNAL OF ORTHOPSYCHIATRY (October 1969) at 753	25
Linn, *State Hospital Environment and Rates of Patient Discharge*, 23 ARCHIVES OF GENERAL PSYCHIATRY (October 1970) at 1	25
1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE (1973)	44
National Association for Mental Health, Position Statement on the Right to Treatment (1970)	39
Note, *Mental Illness: A Suspect Classification?*, 83 YALE L. J. 1237 (1974)	30
Penn, Sindberg & Roberts, *The Dilema of Involuntary Commitment*, MENTAL HYGIENE (January 1969) at 5	25
Pittmen, et al., Family Therapy as an Alternative to Psychiatric Hospitalization, Psychiatric Report No. 20, American Psychiatric Association (February 1966) at 188	25
W. PROSSER, LAW OF TORTS (4th ed. 1971)	20

TABLE OF CITATIONS—Continued

	Page
RESTATEMENT OF TORTS (1938)	20
RESTATEMENT (SECOND) OF TORTS (1965)	20
R. SLOVENKO, PSYCHIATRY AND LAW (1973)	44
1 AM. JUR. 2d, *Abuse of Process* (1962)	20
32 AM. JUR. 2d, *False Imprisonment* (1967)	20
35 C.J.S., *False Imprisonment* (1960)	20
72 C.J.S., *Process* §§ 119-124 (1951)	20

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner,

v.

KENNETH DONALDSON,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

---

BRIEF FOR AMICI CURIAE AMERICAN ASSOCIATION ON MENTAL DEFICIENCY; AMERICAN FEDERATION OF STATE, COUNTY & MUNICIPAL EMPLOYEES, AFL-CIO; AMERICAN ORTHOPSYCHIATRIC ASSOCIATION; AMERICAN PSYCHOLOGICAL ASSOCIATION; JOSEPH P. KENNEDY, JR., FOUNDATION; NATIONAL ASSOCIATION FOR MENTAL HEALTH; NATIONAL ASSOCIATION FOR RETARDED CITIZENS; NATIONAL CENTER FOR LAW AND THE HANDICAPPED; NATIONAL SOCIETY FOR AUTISTIC CHILDREN

INTEREST OF AMICI CURIAE

This brief amicus curiae is filed, pursuant to consents filed with the Clerk, on behalf of the American Association on Mental Deficiency, the American Federation of State, County & Municipal Employees, AFL-CIO, the American Orthopsychiatric Association, the American Psychological Association, the Joseph P. Kennedy, Jr., Foundation, the National Association for Mental Health, the National Association for Retarded Citizens, the National Center for Law and the Handicapped, and the National Society for Autistic Children.

The amici include both professional and employee associations, representing the interests of institutional personnel, and "consumer" organizations, representing the interests of institutionalized persons and their families.[1]

[1] The American Association on Mental Deficiency is an organization made up of over 9,000 professionals in the mental deficiency field, many of whom are employed in public facilities for the mentally retarded. The American Federation of State, County & Municipal Employees, AFL-CIO, is an employee organization representing approximately 1,250,000 public employees; among its 700,000 members, some 85,000 are mental health workers. The American Orthopsychiatric Association is an interdisciplinary association concerned with the problems of mental disorder and abnormal behavior. The American Psychological Association has a membership of approximately 40,000 psychologists, many of whom are employed in public mental hospitals. The Joseph P. Kennedy, Jr. Foundation is a private foundation concerned with all aspects of mental retardation, including improvement and promotion of the legal and human rights and welfare of retarded children and adults through support of medical, legal and ethical programs. The National Association for Mental Health is a voluntary citizens' organization with approximately one million members working for the prevention of mental illness and the promotion of mental health and the improvement of services for the mentally impaired. The National Association for Retarded Citizens is a voluntary organization with a membership of nearly 300,000 devoted to improving and promoting the welfare of mentally retarded children and adults. The National Center for Law and the Handicapped is jointly sponsored by the American Bar Association/Family Law Section, the Council for the Retarded of St. Joseph County (Indiana), the National Association for Retarded Citizens, and Notre Dame University/Notre Dame Law School, and is supported through joint funding by the Bureau of Education for the Handicapped, Office of Education, and the Division of Developmental Disabilities, Rehabilitative Services Administration, U.S. Department of HEW; it is devoted to securing the legal rights of handicapped persons and ensuring their full participation in the normal life of the community. The National Society for Autistic Children is a voluntary organization devoted to the education and welfare of citizens with severe developmental disorders of communication and behavior.

Thus the amici represent interests on all sides of pending and potential litigation concerning institutional conditions and practices. Accordingly, they are interested not just in fair play for institutional employees *or* in decent institutional conditions and practices, but in both. Moreover, the amici are parties or otherwise involved in a number of important cases involving institutional conditions and practices that may be affected by what the Court does in this case.[2]

SUMMARY OF ARGUMENT

On the instructions given in this case, the jury was authorized to return a verdict for compensatory damages only if it found (a) that respondent Donaldson was in fact not dangerous to himself or others and that petitioner knew he was not, (b) that Donaldson, if mentally ill, was not receiving such treatment as would give him a "realistic opportunity to be cured or to improve his mental condition," and petitioner knew he was not, and (c) that petitioner nevertheless obstructed Donaldson's release. Such findings would render petitioner *prima facie* liable for damages, but the jury was further instructed to find in petitioner's favor if it found that petitioner "reasonably believed in good faith" that continued detention of Donaldson was lawful for *any* reason.

[2] *E.g.*, *Wyatt* v. *Stickney*, 325 F. Supp. 781, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd in part sub. nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974). Local affiliates of the amici are engaged in many different cases across the country.

1. No substantial question is presented in this case relating to the rules of liability of public officials under § 1983. Petitioner does not contend that he is entitled to absolute official immunity. His contention that the decision below means that psychiatrists at state mental hospitals may be held liable for a state's inadequate provision of resources is not supported by the record in this case or any applicable law; petitioner was held liable for obstructing Donaldson's release, not for inadequacies in treatment that may have been caused by the State. Finally, petitioner was not unfairly found liable by the retrospective application of a new constitutional right; under the reasonable good faith belief instruction, petitioner need only have proved that he had had some reason which he reasonably believed to be lawful for blocking Donaldson's release. Not only did he fail, but he was found to have acted maliciously, wantonly or oppressively, as demonstrated by the award of punitive damages. Petitioner's arguments about fairness are principally arguments about the sufficiency of the evidence, which do not warrant review by this Court.

2(a). The Court should not assume that Donaldson would have been constitutionally confined if he had in fact been receiving adequate treatment. There is a substantial constitutional question whether an individual who is neither dangerous to others nor incompetent reasonably to care for himself may properly be continued in involuntary confinement for treatment because he is mentally ill. Such confinement is a massive curtailment of liberties and hence, under fundamental notions of due process, must serve compelling public purposes and restrict liberty no more than necessary to accomplish those purposes. The involuntary confinement of nondangerous individuals who do not lack the capacity reasonably to care for themselves meets neither test. The same conclusion is required as a matter of equal protection, if mentally ill but reasonably competent individuals are

required to submit to hospitalization for treatment while physically ill persons are permitted to decide such questions for themselves. This discrimination involves a "suspect class"—the mentally ill—and it cannot be justified by a sufficient governmental interest.

2(b). Amici strongly endorse the ruling of the court below on the right to treatment. Since Donaldson was committed for treatment but received none, his continued confinement violated the rule of *Jackson* v. *Indiana*, 406 U.S. 715 (1972): the nature of the confinement bore no reasonable relation to its purpose. In addition, however, amici believe that all persons who are civilly committed for mental impairments have a constitutional right to treatment, whether mentally ill or mentally retarded, and whether or not dangerous to others. Commitment without treatment is simply imprisonment for a mental impairment and therefore cannot be squared with Eighth Amendment principles embodied in the Fourteenth Amendment. Since the period of confinement may be indefinite, the allegedly dangerous mentally ill are discriminated against *vis-à-vis* dangerous persons who are not mentally ill, in violation of the Equal Protection Clause. Furthermore, involuntary confinement of the mentally ill violates the Due Process Clause unless treatment is provided to render the confinement nonpunitive, to ensure that the conditions of confinement are no more severe than necessary, and to ensure that the duration of confinement is no longer than necessary.

2(c). The constitutional right to treatment is susceptible to judicial definition and enforcement. Amici and others have been active for years in the establishment and administration of minimum professional standards for treatment. With the aid of published standards and expert opinion, courts can establish minimum requirements for institutional conditions on the one hand, and for the adequacy of individual treatment on the

other. Such review is an essential judicial function if the mentally ill and retarded are to be involuntarily confined; it will not put courts in the business of second-guessing the reasonable judgments of trained physicians and psychologists.

ARGUMENT

Petitioner claims that this case presents substantial issues to the Court. The first such issue is simply stated: whether patients involuntarily committed to a state hospital have a constitutional "right to treatment." The second, obscurely stated,[3] is presented as a substantial issue concerning the scope of liability for monetary damages on the part of mental health personnel at state mental institutions under R.S. § 1979, 42 U.S.C. § 1983 (1970), when patients are found to have been deprived of the aforementioned right.[4]

Amici strongly endorse the holding below on the "right to treatment," though we believe that respondent Donaldson may have been constitutionally entitled to release regardless of whether he was receiving the requisite treatment. In addition, amici believe that the award of damages in the case was made pursuant to unchallenged jury instructions that present no departure from the rulings of this Court, and that petitioner's remaining claims concerning his liability under § 1983 present no question warranting review by this Court. We set forth

[3] The issue is stated in the petition (p. 2) as follows: "Whether, assuming there is a constitutional right to treatment, staff members at a state mental hospital are liable for monetary damages in a suit under the civil rights act." Contrary to the appearance of this issue, petitioner does not argue for absolute official immunity. See Part I(B) *infra*.

[4] Petitioner also presents a third issue—whether respondent waived his right to treatment. Amici have little to add to respondent's discussion of that issue and therefore do not discuss it in this brief.

our views as to both matters below, beginning with the § 1983 issues because we believe them to be the narrower.

In what follows, we have generally relied on facts clearly of record and the factual part of the Court of Appeals opinion (493 F.2d 507, and App. 257), and have addressed the legal issues that those facts present. As to matters of fact that are in dispute, we refer the Court to the briefs of the parties.

I. The Monetary Award Against Petitioner Was Not Improper for Any Legal Reason Generally Applicable to Liability Under § 1983

A. *The Posture of the Case*

On the instructions given in this case, the jury was authorized to return a verdict for compensatory damages only if it found (a) that respondent Donaldson was in fact not dangerous to himself or others and that petitioner knew he was not,[5] (b) that Donaldson, if mentally ill, was not receiving treatment as defined by the instructions,[6] and

[5] The court instructed the jury that to prove his claim under § 1983 the plaintiff must establish by a preponderance of the evidence that the defendants confined plaintiff "knowing that he was not mentally ill *or dangerous* or knowing that if mentally ill he was not receiving treatment for his alleged mental illness." App. 183 (emphasis added). This instruction was clarified in the instructions defining the constitutional right to treatment, quoted in full in note 9 *infra*, where the court said that absent treatment, continued confinement is unlawful "unless you should also find that the Plaintiff was dangerous *to either himself or others*." App. 186 (emphasis added).

[6] The jury was instructed that a person involuntarily civilly committed to a mental hospital had a constitutional right "to receive *such treatment as will give him a realistic opportunity to be cured or to improve his mental condition*." App. 186 (emphasis added). The court went on to observe that "the purpose of involuntary hospitalization is *treatment and not mere custodial care or punishment* if a patient is not a danger to himself or others." *Id.* (emphasis added).

that petitioner knew it,[7] and (c) that petitioner nevertheless obstructed Donaldson's release.[8] These facts alone, under the court's ruling as to the constitutional right to treatment or release,[9] rendered petitioner *prima facie* liable for damages, but the jury was further instructed to find in petitioner's favor if it found that petitioner "reasonably believed in good faith" that continued detention of Donaldson was lawful for *any* reason.[10] In

[7] Plaintiff had to prove that defendants confined plaintiff "knowing that he was not mentally ill or dangerous or *knowing that if mentally ill he was not receiving treatment for his alleged mental illness.*" App. 183 (emphasis added).

[8] That is, the jury was instructed that plaintiff had to prove that defendants "*confined Plaintiff against his will,* knowing that he was not mentally ill or dangerous or knowing that if mentally ill he was not receiving treatment for his alleged mental illness." App. 183 (emphasis added).

[9] The court's full instruction on the constitutional right to treatment read as follows:

> "You are instructed that a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.
>
> "Now, the purpose of involuntary hospitalization is treatment and not mere custodial care or punishment if a patient is not a danger to himself or others. Without such treatment there is no justification from a constitutional stand-point for continued confinement unless you should also find that the Plaintiff was dangerous to either himself or others." App. 186.

[10] "Now, the Defendants in this action have claimed and are relying on the defense that they acted in good faith. Simply put, the Defendants contend they in good faith believed it was necessary to detain Plaintiff in the Florida State Hospital for treatment for the length of time he was so confined.

"If the jury should believe from a preponderance of the evidence that the Defendants reasonably believed in good faith that detention of Plaintiff was proper for the length of time he was so confined then a verdict for Defendants should be entered even though the Jury may find the detention to have been unlawful.

[Footnote continued on page 9]

short, the jury was not permitted to hold petitioner liable merely because the so-called right to treatment had been violated; it was allowed to return a verdict against petitioner only upon a finding that petitioner had no reason *at all* for confining Donaldson that petitioner reasonably believed to be lawful. The jury did so hold, and the Court of Appeals found the evidence sufficient to support the verdict. 493 F.2d at 527; App. 294.

In addition to awarding compensatory damages, however, the jury held petitioner liable for punitive damages as well. To do so, the jury had to find, under the court's instructions,[11] that Donaldson had proved that petitioner

[10] [Continued]

"However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify Plaintiff's confinement in the Florida State Hospital.

"As a corollary Plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual deprivation of constitutional rights or other rights guaranteed by law.

"As to this defense of good faith, the burden is upon the Defendants to prove this defense by a preponderance or a greater weight of the evidence in the case." App. 184-85.

[11] "In addition to actual damages or compensatory damages which are those I just mentioned to you, the law permits the Jury under certain circumstances to award the injured person punitive or exemplary damages in order to punish the wrongdoer for some extraordinary misconduct, and to serve as an example or warning to others not to engage in such conduct.

"If the Jury should find from a preponderance of the evidence in the case that the Plaintiff is entitled to a verdict for actual or compensatory damages, and should further find that the act or omission of the Defendant or Defendants which proximately caused injury to the Plaintiff was maliciously or wantonly or oppressively done, then the Jury may, if in the exercise of discretion, they unanimously choose to do so, add to the award of actual damages such amount as the Jury shall unanimously agree to be proper as punitive and exemplary damages.

"An act or failure to act is maliciously done if prompted or accompanied by ill will, or spite, or grudge, either toward the

acted "maliciously or wantonly or oppressively" in continuing to confine him, as those terms were defined by the court. That is, the jury had to find not only that petitioner lacked what he believed to be a *good* reason for confining Donaldson, but that he continued to confine Donaldson for affirmatively *bad* reasons. Here too the Court of Appeals found the evidence sufficient to support the award. 493 F.2d at 531, App. 301.

With the case in this posture petitioner asks the Court to decide "whether, assuming there is a constitutional right to treatment, staff members at a state mental hospital are liable for monetary damages in a suit under the civil rights act," Brief at 2. That question, so phrased, suggests that the petitioner is claiming (1) that he is absolutely immune from suit under § 1983. However, the discussion in his brief shows instead that he is claiming (2) that he was held liable for lack of treatment caused by inadequate state resources for which he was not himself responsible, Brief at 52, 55-57, and (3) that he was unfairly held liable for violating a new right

injured person individually, or toward all persons in one or more groups or categories of which the injured person is a member.

"An act or a failure to act is wantonly done if done in reckless or callous disregard of, or indifference to, the rights of one or more persons, including the injured person.

"An act or a failure to act is oppressively done if done in a way or manner which injures or damages or otherwise violates the rights of another person with unnecessary harshness or severity, as by misuse or abuse of authority or power, or by taking advantage of some weakness or disability or misfortune of another person.

". . . [T]he Jury should always bear in mind not only the conditions under which and the purposes for which the law permits an award of punitive or exemplary damages to be made, but also the requirement of the law that the amount of such extraordinary damages when awarded must be fixed with calm discretion and sound reason and must never be either awarded or fixed in amount because of any sympathy or bias or prejudice with respect to any party to the case." Appendix filed in the Court of Appeals, at 968-70.

"whose emergence and enforcement could not have been reasonably foreseen." Brief at 52. We deal below with each of these three possible grounds for attacking the decision in this case.

B. *Petitioner Does Not Contend That He is Entitled to Absolute Immunity*

As phrased in petitioner's statement of the questions presented, the question presented with respect to petitioner's individual liability for damages under 42 U.S.C. § 1983 suggests that he is contending that he is absolutely immune from liability by virtue of his official position as a staff member in a state mental hospital. Under the jury's instructions, petitioner was allowed only a qualified immunity for acts done in good faith.[12] The instruction given to the jury in that regard was a straightforward application to the facts of this case of the "reasonable good faith belief" defense which this Court enunciated with respect to state police officers making unconstitutional arrests in *Pierson* v. *Ray*, 386 U.S. 547 (1967).[13] It is consistent with the Court's subsequent ruling regarding the qualified immunity of officers of the executive branch of government in *Scheuer* v. *Rhodes*, 416 U.S. 232, 247-48 (1974),[14] and constitutes an ap-

[12] See note 10 *supra*.

[13] "[I]f the jury found that the officers reasonably believed in good faith that the arrest was constitutional, then a verdict for the officers would follow even though the arrest was in fact unconstitutional." 386 U.S. at 557.

[14] There the Court said the following in connection with an allegation of an unnecessary deployment of the National Guard by high executive officers of a state and the resulting alleged illegal actions by that Guard:

> "These considerations suggest that, in varying scope, a qualified immunity is available to officers of the executive branch of government, the variation being dependent upon the scope of discretion and responsibilities of the office and all the circumstances as they reasonably appeared at the time of the action on which liability is sought to be based. It

propriate solution to the problem of § 1983 liability in this case. The Court of Appeals observed that petitioner had not objected to the instruction regarding the good faith belief defense in the trial court and had not raised the propriety of the instruction on appeal. The Court therefore went on, quite properly, to treat petitioner's arguments as going to the sufficiency of the evidence to support the jury's finding of an absence of good faith (493 F.2d at 527, App. 293).[15] In this Court, far from attempting to claim an absolute immunity, petitioner concedes that

---

is the existence of reasonable grounds for the belief formed at the time and in light of all the circumstances, coupled with good-faith belief, that affords a basis for qualified immunity of executive officers for acts performed in the course of official conduct." 416 U.S. at 247-48.

[15] Petitioner's codefendant, Dr. Gumanis, raised on appeal the failure of the District Court to give the following instruction on "quasi-judicial" immunity, which may be construed as going to the validity of the good faith belief instruction:

> "If you find that the defendants were operating in a quasi-judicial function, in that they, under state law, were making a judgment as to whether or not plaintiff should be released, defendants are immune from liability under the Civil Rights Act." 493 F.2d at 529; App. 298.

This request was based on a line of Ninth Circuit cases holding certain state officers who exercise a "quasi-judicial" or "discretionary" function immune from liability under § 1983. See 493 F.2d at 529-30; App. 298-99.

The Court of Appeals affirmed the rejection of the proposed instruction, following previous decisions in the Second, Fifth, and Seventh Circuits in rejecting the discretionary-versus-ministerial-act distinction as a basis for absolute official immunity. 493 F.2d at 529-30; App. 299-300. It endorsed a "qualified governmental immunity" test, allowing immunity "when (1) the officer's acts were discretionary; *and* (2) the officer was acting in good faith." 493 F.2d at 530; App. 300. The instructions given to the jury were held sufficient under this test. *Id.*

All of the cases discussed by the Court of Appeals, of course, were decided prior to this Court's decision in *Scheuer* v. *Rhodes*, 416 U.S. 232 (1974), discussed in note 14 *supra*.

> "state officers and employees are not entitled to absolute immunity accorded the judiciary, because that would frustrate the intent of . . . § 1983. However, this Court has found that there is limited immunity for acts *done in good faith by state officers*, within the scope of their official duties." Petition for Certiorari at 39 (citations omitted; emphasis added).

In light of this concession, which amici believe to be required by the Court's decisions in *Pierson* v. *Ray* and *Scheuer* v. *Rhodes*, the matter of immunity needs no further discussion.

C. *Petitioner Was Not Held Liable for a Failure to Provide Treatment Resulting from Inadequacy of State Resources for Which He Was Not Responsible*

The initial concern expressed in petitioner's brief with respect to § 1983 liability—whether a psychiatrist in a state hospital may be held liable for inadequate treatment resulting from the inadequate provision of state resources—is no more than a red herring in this case. Petitioner argues:

> "[P]sychiatrists in a state hospital should not be held liable for deprivation of a constitutional right to adequate treatment, when they have no control over the number or nature of the patients they must treat, the facilities and resources available to them, or the statutory right to either refuse to treat a particular patient or release a patient before he is restored to his mental health. The Court of Appeals found such considerations [*inter alia*] without merit." Brief at 52.

And later,

> "If the situation were not as serious as it is [in this case], it would be ludicrous to imagine a federal court finding that an over-worked, underpaid, staff psychiatrist in an over-crowded state hospital, work-

> ing with a patient-staff ratio averaging five hundred patients per physician, using the meager facilities available to him, could be held personally liable . . . to a former patient, for . . . failing to provide each and every patient with 'adequate treatment', pursuant to that right, as determined by a group of laymen." Brief at 57.

The amici on this brief—representing both professionals and staff members of state mental institutions and persons confined in those institutions—naturally share the concern that no decision of this or any other court make it impossible for the best physicians and staff to remain and work at state mental institutions—in particular those institutions which are understaffed by reason of inadequate appropriations from state legislators. These amici, certainly those that represent institutional professionals and staff, would strenuously oppose any rule that could subject such individuals to liability for conditions for which they themselves are not responsible.

It appears clear, however, that no such liability is involved in this case. Petitioner was not held liable for failing to *treat* Donaldson, but for obstructing Donaldson's *release*, knowing that Donaldson was neither dangerous nor receiving treatment. As we have explained, in Part I (A) *supra*, the instructions made it clear to the jury that the gravamen of petitioner's liability under Section 1983 was not his personal failure to provide the requisite treatment but his individual responsibility for Donaldson's continued purposeless confinement. In short, whatever the reason for Donaldson's lack of treatment, liability turned, under the jury instructions, only on petitioner's *knowledge* that Donaldson was not dangerous and not receiving treatment, combined with petitioner's obstruction of Donaldson's release. Thus, petitioner cannot contend that, because of inadequate resources he was given to work with, he could have escaped liability only

by resigning; he could have escaped liability by taking reasonable steps to secure or permit Donaldson's release, or, at the very least, by acting reasonably with respect to efforts by others to secure Donaldson's release.

Petitioner is aware of this feature of the case, and he argues that "he was not statutorily authorized to release Donaldson even though he knew that Donaldson was receiving inadequate treatment . . . ." Brief at 57. However, petitioner did not succeed in proving this contention below, and the Court of Appeals held that there was sufficient evidence that "the defendants wantonly, maliciously or oppressively blocked efforts by responsible and interested friends and organizations to have Donaldson released to their custody," outlining the evidence in that regard (493 F.2d at 515 *et seq.*, App. 271 *et seq.*). In short, it appears clear that there was evidence from which the jury could find, and did find, that petitioner had the authority to take steps which would have led to Donaldson's release and that, instead of taking those steps, or even making a good faith effort to do so, petitioner obstructed every effort that might have led to Donaldson's release.

In view of the importance amici attach to preventing physicians and other staff at inadequately funded state mental hospitals from believing that they must choose between resigning and subjecting themselves to damage actions for conditions beyond their control, we deem it appropriate to make the following additional observations. Even where the gravamen of a cause of action under Section 1983 is the failure to provide adequate treatment—rather than, as in this case, the obstruction of release—there is no case law that suggests that a defendant physician could be held liable for inadequacies in treatment that are beyond his control. Such a doctor is not merely protected by the good faith belief defense, but also by the clear requirement that plaintiff must prove that

the defendant *proximately caused* the deprivation. The jury was so instructed in this case. A physician in the tragic position of being unable to provide adequate treatment to all of the patients assigned to his care ought not and could not be held liable for attempting in good faith to make reasonable distinctions on the basis of need and the treatment he is reasonably able to provide under the circumstances.

In this particular case, there was considerable evidence of petitioner's own role in depriving Donaldson of the treatment to which he was entitled under the court's instructions; this evidence was clearly relevant to petitioner's knowledge of the conditions of Donaldson's confinement. Petitioner had ample opportunity to argue, and did so argue, that "both he and Gumanis did the best they could with available resources, and therefore should not be held personally liable for whatever was done to Donaldson." 493 F.2d at 527, App. 293. The relevant evidence has been thoroughly canvassed by the parties and the Court of Appeals. *Id.* The decisions of the courts below do not stand for the proposition that a physician in petitioner's position may be held liable for conditions he could do nothing to change.

D. *Petitioner's Remaining Claims of Unfairness Present No Important Legal Issue and Are Not Supported by the Record*

Petitioner's principal claim with respect to his liability under § 1983 is expressed in several statements that suggest that the courts below erred as a matter of law in ruling on the good faith belief defense in his case: "a psychiatrist in a state mental hospital should not be held personally liable for the deprivation of a constitutional right, whose emergence and enforcement could not have been reasonably foreseen," Brief at 52; "[petitioner] should be immune from damages in a situation

where he was acting in good faith, according to accepted institutional policy and procedures, and could not reasonably be expected to foresee the future emergence and enforcement of a constitutional right to treatment," Brief at 58; he "acted properly within the statutory and constitutional framework as it existed then," *id.*; and he should not "be penalized in retrospect for actions taken in good faith within the scope of his authority as a hospital superintendent or for judgments made as a physician." *Id.*

As we have said in Part I(B) *supra*, petitioner does not challenge the instruction on good faith that was given to the jury and did not challenge it below. Under that instruction, the jury was directed to find for defendants if it found "that the Defendants reasonably believed in good faith that detention of Plaintiff was *proper* for the length of time he was so confined." See note 10 *supra*. The court further instructed the jury that "mere good intentions which do not give rise to a reasonable belief *that detention is lawfully required* cannot justify Plaintiff's confinement," App. 184, and thus made it clear that the word "proper" meant "legally proper." Accordingly, the case went to the jury on precisely the theory that petitioner now argues to this Court. He had only to convince the jury that he reasonably believed that Donaldson's continued confinement was valid under applicable state law at the time. He failed. He does not say that he was in any way prevented from presenting to the jury whatever arguments he wished about his good faith.

Thus, petitioner's claims of unfairness do not address the legal standard embodied in the instructions and therefore must concern only the sufficiency of the evidence.[16] The difficulty with petitioner's contention in

[16] We note that lower courts have been sympathetic to the notion that such general points as petitioner makes are relevant con-

that regard, however, is that he does not say why he should be found to have acted in reasonable good faith that his conduct was legally proper. Donaldson had been committed, by the end of his confinement, not for 15 months but for 15 years. There was evidence from which the jury could have found that petitioner knew that Donaldson, even if "mentally ill," was not dangerous to himself or others; in addition, there were interested groups willing to take responsibility for Donaldson upon his release; finally, the jury could have found that petitioner knew that Donaldson was not receiving treatment likely to improve his condition and that Donaldson was being confined in conditions which were anything but therapeutic. Given all these conditions, could a psychiatrist in petitioner's position reasonably believe—or even subjectively believe—that he was acting properly in obstructing petitioner's release? The state statute under which Donaldson was confined stated that the purpose of the confinement was "care . . . and treatment".[17] If treatment was not being provided, and if less restrictive,

siderations in testing good faith. See, *e.g.*, *Eslinger* v. *Thomas*, 476 F.2d 225, 229 (4th Cir. 1973) (official action "in unquestioned good faith and in perfect accord with long standing legal principle"); *Skinner* v. *Spellman*, 480 F.2d 539, 540 (4th Cir. 1972) ("reasonable good faith reliance on what was standard operating procedure"); *Briscoe* v. *Kusper*, 435 F.2d 1046, 1058 (7th Cir. 1970) (within the ambit of permissible discretion as it appeared at that time); *Clarke* v. *Cady*, 358 F. Supp. 1156, 1161 (W.D. Wis. 1973) (defendant "reasonably relied upon the validity of prison policies which were not in conflict with then binding authority"); *Taylor* v. *Perini*, 365 F. Supp. 557, 558 (N.D. Ohio 1972) (reliance upon "statutes, regulations or procedures which he believed were entirely proper even though some of them were unwritten"); *McKinney* v. *DeBord*, 324 F. Supp. 928, 930 (E.D. Calif. 1970) ("good faith enforcement of apparently valid rules").

We have no doubt that instructions which clarify the contours of the good faith belief defense, and relate it more specifically to the evidence in a particular case, will frequently be appropriate, if not required by law.

[17] 27 FLA. STAT. § 394.09 (1955) (repealed July 1, 1972).

but nevertheless safe, alternatives were known to be available to Donaldson, we are at a loss to understand petitioner's argument for a good faith belief that he was acting properly, and we are at a loss to understand his claim of unfairness when his conduct toward Donaldson turns out to have been a violation of constitutional law.

In *Whirl* v. *Kern*, 407 F.2d 781 (5th Cir. 1969), a sheriff had detained the plaintiff, who had been arrested and indicted for two felonies, in jail for almost nine months after the dismissal of the indictments against plaintiff; a breakdown in communications between the District Clerk's office and the Sheriff's office had occurred. The Court of Appeals held that the sheriff's ignorance was no defense to an action under § 1983 for damages for false imprisonment. It said:

> "The tort of false imprisonment is an intentional tort. . . . It is committed when a man intentionally deprives another of his liberty without the other's consent and without adequate legal justification. . . . Failure to know of a court proceeding terminating all charges against one held in custody is not, as a matter of law, adequate legal justification for an unauthorized restraint. Were the law otherwise, Whirl's nine months could easily be nine years, and those nine years, ninety-nine years, and still as a matter of law no redress would follow. The law does not hold the value of a man's freedom in such low regard." 407 F.2d at 792.

What the court in *Whirl* v. *Kern* feared, occurred, in effect, in this case. We cannot believe that the law holds Donaldson's freedom in such low regard that after 15 years confinement "for treatment," petitioner can escape liability under § 1983 when the jury found, on sufficient evidence, that he had no plausible reason whatsoever for obstructing Donaldson's release.

Finally, petitioner's arguments about good faith and unfairness seem particularly inappropriate when he has been found by the jury not just to have obstructed Donaldson's release without a reasonable good faith belief in the legality of his conduct, but to have acted "maliciously or wantonly or oppresively," as those terms were defined in the instructions on punitive damages (note 11 *supra*). The Court of Appeals found the evidence sufficient for the award of punitive damages. 493 F.2d at 531, App. 301, and, generally, at 493 F.2d at 510-18, App. 262-77. In effect, there was sufficient evidence that petitioner grossly abused his discretion and his office, obstructing Donaldson's release for reasons of personal malice since he viewed Donaldson as a troublemaker, or, at the very least, obstructing Donaldson's release in grossly careless disregard of any legal rights that Donaldson might have had.

Such conduct on the part of a state official with authority to release someone involuntarily confined, has long been actionable under § 1983 and, indeed, under common law.[18] Even if such an official may have had a *subjective* good faith belief that his conduct would not be subject to any legal penalties, malicious, wanton or oppressive conduct is not compatible with the kind of *reasonable* good faith belief in legality which should be required to protect such a state official from liability under Section 1983, when his impression of his legal position turns out to have been incorrect.

[18] For the purposes of § 1983, such a rule follows *a fortiori* from *Whirl* v. *Kern*, 407 F.2d 781 (5th Cir. 1969), discussed *supra*. Under the common law of most states, such conduct would constitute either false imprisonment, which ordinarily does not require proof of malice, or abuse of process, which does. See generally RESTATEMENT (SECOND) OF TORTS (1965) §§ 35-45A; RESTATEMENT OF TORTS (1938) § 682; W. PROSSER, LAW OF TORTS (4th ed. 1971) § 121; 1 F. HARPER & F. JAMES, LAW OF TORTS (1956) §§ 3.6-3.9, 4.9; 35 C.J.S., *False Imprisonment* (1960); 72 C.J.S., *Process* §§ 119-24 (1951); 1 AM. JUR. 2d, *Abuse of Process* (1962); 32 AM. JUR. 2d, *False Imprisonment* (1967).

E. *Conclusion*

Petitioner's claims regarding liability for damages under § 1983 do not challenge the relevant jury instructions, which were wholly consistent with the decisions of this Court. Instead, they concern the sufficiency of the evidence to support a verdict for respondent Donaldson. These claims present no novel legal issue warranting review by this Court. In particular, petitioner's claim that the award of monetary damages in this case will put dedicated physicians at state institutions in an intolerable dilemma is not supported by the record.

II. Respondent's Continued Confinement was Unconstitutional Because He Was Not Dangerous or Incompetent and Because He Was Denied His Constitutional Right to Treatment.

Under the instructions in this case, respondent Donaldson's continued confinement by petitioner was not unlawful if Donaldson was found to have been dangerous either to himself or to others.[19] If, however, the jury found him to have been neither, they were instructed that he had a constitutional right to such treatment of his mental illness as would give him a "realistic opportunity to be cured or to improve his mental condition."[20] If he was found not to have received such treatment, his continued confinement was unlawful. Thus, by returning a verdict in favor of Donaldson, the jury necessarily found that Donaldson was not dangerous to himself or

[19] That is, under the instructions on the elements of the § 1983 cause of action, the jury had to find that Donaldson was not dangerous and that petitioner knew it. See note 5 *supra*. The right to treatment instructions, quoted in full in note 9 *supra*, made clear that "dangerous" meant "dangerous to self or others" by saying that there was no constitutional justification for continued confinement "unless you should also find that the Plaintiff was *dangerous to either himself or others*." App. 186 (emphasis added).

[20] See notes 6 and 7 *supra*.

others, and that he was not receiving the treatment for his mental illness to which he was entitled. The Court of Appeals found the evidence sufficient to support these findings and approved the instruction on the constitutional right to treatment.[21]

The amici on this brief, intimately concerned with the rights of civilly committed persons as well as the rights of physicians and staff at state mental institutions, strongly endorse the holding of the Court of Appeals on the right to treatment. For too long the rights of civilly committed persons have received scant protection in the United States, and we welcome the recent judicial attention to this broad class of citizens.

In Parts (B) and (C) of this section of our brief, we set forth in detail the reasons why a right to treatment for civilly committed persons is required by the most fundamental notions of constitutional law. Before turning to that important question, however, we wish to call the Court's attention to a logically antecedent problem that is equally important. Donaldson claims that he could *not* be confined if he was *not* provided with treatment. It should not be assumed, however, that he *could* be confined constitutionally if he *was* provided with treatment. The jury apparently believed that Donaldson was neither dangerous to others nor incompetent to care for himself outside a confining institution, since under the trial court's instructions they could not return a verdict for Donaldson unless they found that he was not "dangerous to himself or others."[22] We think that the involuntary commitment of such a person—one who is neither dangerous to others nor incompetent reasonably to care for himself—is *not* constitutional, whatever psychiatric difficulties he may have, and we therefore urge the Court, in dealing with Donaldson's right to treatment, to say nothing to suggest that a supposed need for treatment can justify the involuntary confinement of a person who is neither dangerous to others nor incompetent to care for himself. We set forth the basis for our view as to this matter in Part (A) of this section, after which we deal with the right to treatment itself in Parts (B) and (C) below.

[21] See generally 493 F.2d at 510-18, App. 262-77, on the evidence; and 493 F.2d at 518-27, App. 277-93, on the propriety of the instruction on the right to treatment. Respondent's brief thoroughly canvasses the evidence in the record.

[22] See note 19 *supra*.

A. *Persons Like Respondent Who are Neither Dangerous nor Incompetent Cannot Constitutionally be Hospitalized Against Their Will, Whether or Not They Are Given Treatment.*

As the Court of Appeals noted, there are both police power and *parens patriae* rationales for involuntary civil commitments. Three grounds for such commitments appear in the state statutes: danger to others, danger to self (which encompasses incompetency to care for oneself), and need for care or treatment.[23] The commitment of persons who are dangerous to others is ordinarily justified as an exercise of the police power.[24] The commitment of persons who are not dangerous to others but who are dangerous to themselves or unable to care for themselves and who are therefore in need of care or treatment is ordinarily justified by a *parens patriae* rationale,[25] except that where willful self-destruction is threatened, police power considerations may also be in-

[23] 493 F.2d at 520-21, App. 280-83; *Developments in the Law—Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1202-04 (1974) (hereinafter cited as "*Developments—Civil Commitment*").

[24] 493 F.2d at 521, App. 282; *Developments—Civil Commitment*, 87 HARV. L. REV. at 1223.

[25] 493 F.2d at 521, App. 282-83; *Developments—Civil Commitment*, 87 HARV. L. REV. at 1209-10.

volved.[26] However, continued involuntary hospitalization for treatment of an individual who is neither dangerous to others nor incompetent reasonably to care for himself appears to be unconstitutional under both the Due Process Clause and the Equal Protection Clause of the Fourteenth Amendment.

"There can no longer be any doubt that the nature of the interests involved when a person . . . [is] involuntarily committed . . . is 'one within the contemplation of the "liberty and property" language' " of the Due Process Clause of the Fourteenth Amendment.[27] As this Court has observed, civil commitment involves a "massive curtailment of liberty." [28] Donaldson was confined to the Chattahoochee facility for 15 years, and was denied freedom of movement within the hospital and liberty of the grounds during the greater part of that period. 493 F.2d at 513; App. 268. The curtailment of his liberty extended to a whole range of "fundamental" constitutionally protected interests—his basic privacy,[29] his most intimate relations,[30] his freedom of association,[31] his right to travel about,[32] and almost every aspect of his day-to-day life. As the court below stated, "The destruction of an individual's personal freedoms effected by civil commitment is scarcely less total than that effected by confinement in a penitentiary." 493 F.2d at 520; App. 280. More-

[26] 493 F.2d at 521, App. 283; *Developments—Civil Commitment* 87 HARV. L. REV. at 1225-27.

[27] *In re Ballay*, 482 F.2d 648, 655 (D.C. Cir. 1973).

[28] *Humphrey* v. *Cady*, 405 U.S. 504, 509 (1972).

[29] See testimony quoted in 493 F.2d at 511-12, n.5, App. 264-65.

[30] See, *e.g.*, *Eisenstadt* v. *Baird*, 405 U.S. 438, 453 (1972); *Griswold* v. *Connecticut*, 381 U.S. 479 (1965).

[31] See, *e.g.*, *NAACP* v. *Alabama*, 357 U.S. 449, 462 (1958); *NAACP* v. *Button*, 371 U.S. 415, 430-31 (1963).

[32] See *Shapiro* v. *Thompson*, 394 U.S. 618 (1969).

over, involuntary hospitalization for mental illness may stigmatize the patient indefinitely,[33] and indefinite long-term confinement in an overcrowded, understaffed, underfunded, poorly maintained facility like Chattahoochee is likely to cause deterioration of the patient.[34]

Under this Court's decisions, such a "massive curtailment" of fundamental constitutionally protected liberties must (a) serve compelling public purposes [35] and (b) restrict liberty no more than necessary to accomplish those purposes.[36] The involuntary hospitalization for treat-

[33] *Developments—Civil Commitment* 87 HARV. L. REV. at 1198-1201. As this Court has held, stigmatization constitutes a deprivation of liberty in the constitutional sense. *Board of Regents* v. *Roth*, 408 U.S. 564, 573 (1972). See also *Wisconsin* v. *Constantineau*, 400 U.S. 433 (1971).

[34] See Pittmen, *et al.*, Family Therapy as an Alternative to Psychiatric Hospitalization, Psychiatric Report No. 20, American Psychiatric Association (February 1966) at 188; Langsley, *et al.*, *Follow-up Evaluation of Family Crisis Therapy*, 39 AMERICAN JOURNAL OF ORTHOPSYCHIATRY (October 1969), at 753, 759; FRAZIER & CARR, INTRODUCTION TO PSYCHOPATHOLOGY (1964) at 224; Linn, *State Hospital Environmental and Rates of Patient Discharge*, 23 ARCHIVES OF GENERAL PSYCHIATRY (October 1970) at 1. See also FAIRWEATHER ET AL., COMMUNITY LIFE FOR THE MENTALLY ILL—AN ALTERNATIVE TO INSTITUTIONAL CARE (1969) at 10; Penn, Sindberg & Roberts, *The Dilemma of Involuntary Commitment*, MENTAL HYGIENE (January 1969) at 5.

[35] *Roe* v. *Wade*, 410 U.S. 113 (1973). The Court said:

> "Where certain 'fundamental rights' are involved, the Court has held that regulation limiting these rights may be justified only by a 'compelling state interest,' . . . and that legislative enactments must be narrowly drawn to express only the legitimate state interests at stake." 410 U.S. at 155.

Cf. In re Griffiths, 413 U.S. 717, 721-22 and n. 9 (1973).

[36] *Goldblatt* v. *Town of Hempstead*, 369 U.S. 590, 594-96 (1962) (for a valid exercise of the police power, the means employed must be "reasonably necessary for the accomplishment of the purpose, and not unduly oppressive upon individuals.") See *Roe* v. *Wade*, *supra* note 35; *Kesselbrenner* v. *Anonymous*, 33 N.Y.2d 161, 305 N.E.2d 903, 350 N.Y.S.2d 889 (1973) (statute permitting transfer of patient from hospital under control of department of mental

ment of an individual who (a) is not dangerous and (b) does not lack the capacity reasonably to care for himself and make his own treatment decisions meets neither test.

No substantial, much less compelling, public interest is served by forcing such an individual to submit to treatment against his will, certainly no purpose sufficient to justify the massive curtailment of liberty entailed by involuntary hospitalization. That is true whether the state's police power or its role as *parens patriae* is thought to be invoked. The state's police power may empower it to compel a Jehovah's Witness to submit to a blood transfusion where her *life* is at stake,[37] although there is impressive authority that even then a competent individual's refusal to be treated is "strictly a private concern and thus beyond the reach of all governmental power." [38] So, too, the police power may justify requiring an individual to act in a way that is thought to serve his health and welfare, as by refraining from the

hygiene to hospital primarily for confinement of mentally ill convicted criminals held unconstitutional; "[t]o subject a person to a greater deprivation of personal liberty than necessary to achieve the purpose for which he is being confined is . . . violative of due process," *id.* at 165, 305 N.E.2d at 905, 350 N.Y.S.2d at 892). See also lower court authorities cited in *Developments—Civil Commitment*, 87 HARV. L. REV. at 1328-29 n.49. The least restrictive alternative analysis is discussed in Chambers, *Alternatives to Civil Commitment of the Mentally Ill: Practical Guides and Constitutional Imperatives*, 70 MICH. L. REV. 1108 (1972), and Wormuth & Mirken, *The Doctrine of Reasonable Alternatives*, 9 UTAH L. REV. 254 (1964).

[37] *Application of President and Directors of Georgetown College, Inc.*, 331 F.2d 1000 (D.C. Cir.) (single-judge), *rehearing denied*, 331 F.2d 1010, *cert. denied*, 377 U.S. 978 (1964).

[38] See *In re Estate of Brooks*, 32 Ill. 2d 361, 205 N.E.2d 435 (1965). The words quoted in the text are from *Application of President and Directors of Georgetown College, Inc.*, *supra*, 331 F.2d at 1015, 1016 (separate opinion of Burger, J., concurring in denial of petition for rehearing *en banc* for want of a justiciable controversy).

use of narcotics,[39] as long as the restriction on individual freedom of action is relatively small. The police power might even justify encroachment on constitutionally protected interests, as in the involuntary vaccination of persons whose religious beliefs do not permit them to consent, if the encroachment is slight and the protection of other persons is at stake.[40] But, when neither life nor safety of others is involved, as in the case of a harmless mentally ill individual who is not incompetent, there is no police power interest in treatment sufficient to justify the massive curtailment of liberty involved in indefinite involuntary hospitalization. The *parens patriae* power provides no better justification. That power historically extended to "persons who had lost their intellects and became . . . incompetent to take care of themselves." [41] But the reason for the power—the inability of incompetents to make their own decisions as to their needs—has no application to those numerous individuals who are not incompetent even though they suffer from what may be termed a "mental illness." [42] Many such

[39] *E.g.*, *Commonwealth* v. *Leis*, 355 Mass. 189, 243 N.E.2d 898 (1969).

[40] See *Jacobson* v. *Mass.*, 197 U.S. 11 (1905); *Winters* v. *Miller*, 464 F.2d 65, 70 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971). *But cf. Canterbury* v. *Spence*, 464 F.2d 772, 780 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

[41] *Developments—Civil Commitment*, 87 HARV. L. REV. at 1208 n. 41, citing *In re Barker*, 2 Johns Ch. 232, 236 (N.Y. 1816), citing in turn *Beverley's Case*, 4 Co. Rep. 123b, 127a-28a, 76 Eng. Rep. 1118, 1125-26 (K.B. 1603); 1 W. BLACKSTONE, COMMENTARIES *304.

[42] *Developments—Civil Commitment*, 87 HARV. L. REV. at 1212-1219. We note, in addition, that an individual's *own* competency to care for himself should not be the sole consideration. Relatives or friends may prove willing and able to provide adequate care and supervision of a mentally ill individual. In Donaldson's own case, an old friend made repeated offers to care for Donaldson, 493 F.2d at 516-17, App. 272-75. Initial or continued confinement in such cases is not justifiable unless the State can demonstrate good reason for believing or fearing that release to another's care or custody will not adequately protect the individual.

people can and do lead lives of the utmost productivity outside of confining institutions.

Accordingly, fundamental notions of due process of law compel the conclusion that a non-dangerous mentally ill person who is not incompetent reasonably to care for himself cannot be required to submit to continued hospitalization for treatment, however "adequate" that treatment may be.[43]

The same conclusion is required as a matter of equal protection. Civil commitment statutes authorize different treatment of the mentally ill and the physically ill by requiring mentally ill persons to submit to hospitalization for treatment while allowing physically ill persons to decide such questions for themselves. Mentally ill persons, however, may be as capable of evaluating the desirability of medical treatment and hospitalization as persons who are physically ill. Therefore, there is no rational basis for the discrimination involved in the commitment of non-dangerous mentally ill persons who are not incompetent reasonably to care for themselves and make their own treatment decisions. The discrimination clearly does not serve a *compelling* governmental interest and therefore cannot withstand the strict scrutiny required where, as here, curtailment of fundamental constitutionally protected rights is involved,[44] and where the discrimination involves a "suspect class"—the mentally ill—under criteria previously outlined by this Court.[45]

[43] See *Lessard* v. *Schmidt*, 349 F. Supp. 1078, 1094 (E.D. Wis. 1972) (three-judge court), *vacated & remanded on other grounds*, 414 U.S. 473 (1974).

[44] *San Antonio Indep. School Dist.* v. *Rodriguez*, 411 U.S. 1, 29-34 (1973); *Dunn* v. *Blumstein*, 405 U.S. 330, 336-42 (1972).

[45] In *San Antonio Indep. School Dist.* v. *Rodriguez*, 411 U.S. 1, 28 (1973), this Court identified "the traditional indicia of suspectness"—whether the class is "saddled with such disabilities or subject to such a history of purposefully unequal treatment or

relegated to such a position of political powerlessness as to command extraordinary protection from the majoritarian political process." The mentally ill, particularly those who are institutionalized, meet all three of those criteria. Their disabilities render them politically impotent; indeed, they are frequently disenfranchised altogether. They have been subjected historically to purposefully unequal treatment *vis-à-vis* persons who are not mentally ill. And they have been relegated to a position of political powerlessness by disenfranchisement and other means. This has been true to so great an extent that the history of conditions in state institutions for the mentally impaired cries out for protection from the gross neglect that has been imposed for so long by the majoritarian political process.

These conditions are exposed by the record in this case and the records in numerous pending cases concerning institutional conditions. *E.g.*, *Wyatt* v. *Stickney*, 325 F. Supp. 781 (M.D. Ala. 1971), 344 F. Supp. 387 (M.D. Ala. 1972), *aff'd in part sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. 1974); *New York State Association for Retarded Children* v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973); *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974). For example, in *Wyatt*, Alabama's principal facility for the mentally retarded had been evaluated by the amicus AAMD several years before the commencement of the *Wyatt* litigation. The evaluators identified numerous conditions that were incompatible with even the most primitive notions of ordinary human decency. For example, evaluators found that in a ward of ambulatory severely retarded young boys: "Ground food was brought to the day room in a very large aluminum bowl along with nine metal plates and nine mental spoons. Nine working residents were sent in to feed these 54 young boys from this one bowl of food and nine plates and nine spoons. The feeding was accomplished in a total state of confusion. Since there were no accommodations to even sit down to eat, it was impossible to tell which residents had been fed and which had not been fed with this system." Evaluation at 11-12.

The conditions of gross neglect identified by the AAMD had not been corrected several years later when the *Wyatt* litigation was instituted. Indeed, as Judge Johnson found, conditions in the facility endangered life itself. Thus, shortly before the filing of suit four residents died due to understaffing, lack of supervision and brutality. One had a garden hose inserted in his rectum for five minutes by a working inmate who was cleaning him; one died when a fellow inmate hosed him with scalding water; another died when soapy water was forced into his mouth; and the last died by a self-administered overdose of drugs which had been inadequately secured. Transcript of Hearing, February 28-March 1, 1972, at 99, 101-02, 104, 126-27.

[Footnote continued on page 30]

In view of the jury's apparent conclusion that Donaldson was neither dangerous to others nor incompetent, Donaldson's continued detention for treatment thus appears to have been unconstitutional even if treatment was available for him. If we are right about that, the instruction that Donaldson was entitled to release if he was not receiving treatment was overly favorable to petitioner; the jury could have been instructed simply that if Donaldson was neither dangerous to others nor incompetent and petitioner knew it, then the continued confinement was unlawful; in that event petitioner would be liable for obstructing Donaldson's release, subject to the Court's further instructions on the good faith belief defense. Since the parties did not explore this issue in the courts below and have not briefed it here, this is not an appropriate case in which to decide whether the involuntary hospitalization of a person who is neither dangerous to others nor incompetent is unconstitutional. But if the involuntary hospitalization of such an individual is unconstitutional, as we believe, then the question

[45] [Continued]

Conditions in the state's facilities for the mentally ill were no better. The state's own consultant found that "wards are overcrowded, most frequently without even a minimum of privacy for the patients. For the most part there are no partitions between the stools in the bathroom and no individual furniture where patients could keep clothing. Many of the living areas are essentially large dormitories with 40 to 50 or 60 beds placed row on row (it impressed me as a depressing and dehumanizing environment, reminding me of graveyard lots where the patients are essentially living out their lives without the rights of privacy (or ownership))." Consultant Report of Dr. William Tarnower, (Exhibit X of Defendants' Report to the Court dated September 23, 1971 at 1).

The records in these cases confirm the existence of conditions today that shock the conscience yet have existed for years, demonstrating the political impotence of this unfortunate group of human beings.

See generally, Note, *Mental Illness: A Suspect Classification?*, 83 YALE L.J. 1237 (1974).

tion whether confined persons like Donaldson have a right to release if they are not treated does not arise. That is, the question whether there is a right to release in the absence of treatment, the question petitioner asks this Court to decide, is tendered in this case in connection with persons who are entitled to release without regard to treatment. Since certiorari has been granted, however, on a petition which raises the issue, and since amici strongly endorse the right to treatment with respect to those who are constitutionally confined, we discuss the right to treatment question in the remainder of this brief.

B. *Persons Committed for Mental Impairments Have a Constitutional Right to Treatment*

As we have seen, the case directly presents only the question whether a mentally ill person who has been civilly committed but who is not dangerous to himself or others has a right to treatment or release.[46] It therefore involves a person as to whom the only conceivable ground for detention is the need for treatment—a person who is subject to commitment, if at all, only under the *parens patriae* power.

In this particular case, the relevant state statute explicitly set out the purpose for civil commitment and for the "massive curtailment" of fundamental liberties that such commitment entails: respondent Donaldson was committed for "care, custody *and treatment.*"[47] Since the jury necessarily found that Donaldson was dangerous neither to himself nor to others, there is no rational way to avoid the conclusion that Donaldson was entitled to treatment or release under the rule of *Jackson* v. *Indiana*, 406 U.S. 715 (1972). There the Court held: "At

[46] See pp. 21-22 *supra*.

[47] 27 FLA. STAT. § 394.09 (1955) (repealed July 1, 1972).

the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." 406 U.S. at 738. As Judge Johnson said in *Wyatt* v. *Stickney*,[48] the Alabama minimum institutional standards case, "To deprive any citizen of his or her liberty on the altruistic theory that confinement is for humane therapeutic reasons and then fail to provide adequate treatment violates the very fundamentals of due process." 325 F. Supp. at 785. Accordingly, the Court of Appeals below correctly ruled: "If the 'purpose' of commitment is treatment, and treatment is not provided, then the 'nature' of the commitment bears no 'reasonable relation' to its 'purpose', and the constitutional rule of *Jackson* is violated." 493 F.2d at 521; App. 283.

While this ground is dispositive of Donaldson's case, and the case of any person who is confined for treatment and found to be neither dangerous nor receiving sufficient treatment to justify prolonged confinement, amici believe it is clear that *all* persons who are civilly committed for mental impairments have a constitutional right to treatment as the term was defined by the Court of Appeals,[49] whether they are mentally ill or mentally

[48] 325 F. Supp. 781, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd in part sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974).

[49] The Court of Appeals held

> "that a person involuntarily civilly committed to a state mental hospital has a constitutional right to receive such individual treatment as will give him a reasonable opportunity to be cured or to improve his mental condition." 493 F.2d at 520; App. 280.

It later elaborated on the standard, in terms more directly applicable to the mentally retarded: "rehabilitative treatment, or, where rehabilitation is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary." 493 F.2d at 522; App. 284. See also *Wyatt* v. *Stickney, supra*, 344 F. Supp. at 390, where the court

retarded; whether they are harmless or dangerous; and whether they are committed under the *parens patriae* power or the police power. The right derives from the Due Process and Equal Protection Clauses of the Fourteenth Amendment, and from Eighth Amendment principles that are applicable to the states under the Fourteenth Amendment. Amici endorse this more general principle for at least four reasons:

1. Without treatment, involuntary hospitalization in a so-called mental hospital does not differ in any material way from penal imprisonment. "Absent treatment, the hospital is transformed into a 'penitentiary where one could be held indefinitely for no convicted offense.'"[50] The conditions of Donaldson's own confinement—locked wards, padlocked windows, severe restrictions on movement within the hospital, assigned tasks of menial labor, confinement with criminal patients, the absence of privacy[51]—make this point in a particularly vivid way. Thus, commitment without treatment is simply imprisonment for a mental impairment and therefore cannot be squared with Eighth Amendment requirements embodied in the Fourteenth Amendment. As this Court said in *Robinson* v. *California*, 370 U.S. 660 (1962):

> "It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A State might determine that the victims of these and other human afflictions be dealt with by compulsory treatment,

said that mentally retarded patients have a constitutional right to "such individual habilitation as will give each of them a realistic opportunity to lead a more useful and meaningful life and to return to society."

[50] *Wyatt* v. *Stickney, supra*, 325 F. Supp. at 781.

[51] See Donaldson's testimony below, App. 40-51; quoted in part in 493 F.2d at 511-12 n.5, App. 264-65.

> involving quarantine, confinement or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments." 370 U.S. at 666.

These requirements cannot be evaded by adopting sham treatment programs—by the "hanging of a new sign reading 'hospital' over one wing of the jailhouse." *Powell* v. *Texas*, 392 U.S. 514, 529 (1968).

2. Moreover, mentally ill persons who are believed to be dangerous are imprisoned indefinitely, sometimes upon a mere prediction by a physician as to possible future conduct. In contrast, we do not imprison beyond the terms of their sentences persons who are *not* mentally ill, who have *demonstrated* that they are capable of violence by actually committing serious crimes. Even then, they are confined only after conviction pursuant to rigorous procedural safeguards. This discrimination demands strict scrutiny under the Equal Protection Clause,[52] because the mentally ill are a "suspect" class, and "fundamental" interests are at stake.[53] The discrimination against mentally ill persons who *may* be dangerous, *vis-à-vis* sane persons who have *proved* their capacity for violence, serves no rational end whatever, much less a compelling one.

3. Additionally, since confinement without treatment does not differ materially from penal confinement, commitment without observing procedures required as a matter of due process in criminal cases violates the Due Process Clause directly. As the Court below pointed out,[54]

[52] See Part II(A) *supra*.

[53] See note 45 *supra*.

[54] 493 F.2d at 521-22; App. 283-84.

long-term detention is, as a matter of due process, generally allowed only when an individual is (1) proved to have committed a specific offense (2) in a proceeding subject to the rigorous procedural requirements of the Bill of Rights and the Due Process Clause. Even then, his confinement is ordinarily allowed only for a fixed period of time limited by statute and set in his sentence. These limitations are not observed in civil commitments. Thus, Donaldson was committed indefinitely upon the certification of two physicians that they believed that he needed restraint "to prevent him from self injury or violence to others."[55] If preventive detention in such circumstances can be justified at all, it is only because treatment is to be provided, rendering confinement nonpunitive in character.

4. Finally, unless treatment is provided, indefinite confinement is not likely to cure the illness that is the occasion for confinement. Rather, it is likely to lead to further deterioration, thereby prolonging confinement indefinitely. A number of studies by these amici and others document that conclusion.[56] Thus, confinement without treatment is not the least restrictive alternative available for protecting society from dangerous mentally ill persons and therefore cannot be squared with the due process requirement that the State cannot restrict fundamental liberty except in ways *necessary* to accomplish compelling public objectives.[57]

For these reasons, non-penal confinement of mentally impaired individuals without treatment is unconstitutional. Treatment is the necessary element that distinguishes civil confinement from mere imprisonment, thus

[55] See App. 189.

[56] See authorities cited in note 34 *supra*.

[57] See 27 FLA. STAT. § 394.22(11)(a) (1955) (repealed July 1, 1972); App. 249.

avoiding the constitutional difficulties outlined immediately above. In these circumstances, it is not surprising that an impressive body of precedent has developed, summarized by the Court below, 493 F.2d at 521-25, App. 283-89, supporting the conclusion that treatment is the necessary *quid pro quo* for the "massive curtailment of liberty" that results from civil commitment. There are decisions supporting the view that treatment is required in each of the major forms of non-penal facilities operated by the states—those for the mentally ill,[58] the mentally retarded,[59] non-delinquent juveniles in need of supervision,[60] juvenile delinquents,[61] and facilities for persons confined under "non-penal" sex-offender and defective delinquent statutes.[62] Surely if sex-offenders and defective delinquents have a right to treatment, mentally ill and retarded persons have no lesser rights.

C. *The Right to Treatment is Not Nonjusticable for Lack of Judicially Manageable Standards*

Petitioner's principal attack on the right to treatment is his claim that it is not susceptible of judicial definition and enforcement. (Brief at 29-45.) He notes that there are many matters over which mental health pro-

[58] *Wyatt* v. *Stickney*, *supra* note 48; *Stachulak* v. *Coughlin*, 364 F.2d 686 (N.D. Ill. 1973).

[59] *Wyatt* v. *Stickney*, *supra*; *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974). *But see*, *New York State Ass'n for Retarded Children, Inc.* v. *Rockefeller*, 357 F. Supp. 752 (E.D.N.Y. 1973).

[60] *Martarella* v. *Kelley*, 349 F. Supp. 575, *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1972). See also *In re Gault*, 387 U.S. 1, 22 n.30 (1967).

[61] *Nelson* v. *Heyne*, 491 F.2d 352 (7th Cir. 1974), *affirming* 355 F. Supp. 451 (N.D. Ind. 1972); *Inmates of Boys' Training School* v. *Affleck*, 364 F. Supp. 1354 (D.R.I. 1972); *Morales* v. *Turman*, 364 F. Supp. 166 (E.D. Tex. 1973).

[62] *Sas* v. *Maryland*, 334 F.2d 506 (4th Cir. 1964); *Davy* v. *Sullivan*, 354 F. Supp. 1320 (M.D. Ala. 1973) (three-judge court).

fessionals disagree and many recognized forms of therapy available for different mental impairments, and concludes that enforcement of the right to treatment will require judges and juries "to second guess the judgment of trained physicians and psychologists concerning what constitutes 'adequate treatment.'" (Brief 30.)

By "right to treatment," the court below meant the right to such treatment as will give the patient "a reasonable opportunity to be cured or to improve his mental condition," or "where rehabilitative treatment is impossible, minimally adequate habilitation and care, beyond the subsistence level custodial care that would be provided in a penitentiary." 493 F.2d at 520-522, App. 280-84.[63] These are meaningful and enforceable standards. As long as the hospital and its staff provide services to cure or improve the condition of the patient that are within the range of accepted professional practice, the patient is receiving the treatment to which he is entitled. While there are questions on which mental health professionals disagree, as in other fields of medicine, there are also matters on which there is consensus. For example, all responsible professionals would agree that when the ratio of psychiatrists and psychologists to patients falls below a certain fraction at an institution, proper treatment of any but a small number of patients is impossible.[64] All responsible professionals would agree that the "milieu" of Chattahoochee described in the record[65] was for the most part anti-therapeutic in character. All responsible professionals would agree that without individual treatment plans of some sort, extended confine-

[63] See also note 49 *supra*.

[64] The minimally acceptable ratio, it should be noted, will depend on the type of treatment that the institution purports to offer. Some behavior modification plans may require fewer administering staff than, say, psychotherapy.

[65] See testimony quoted in 493 F.2d at 511-12, n.5, App. 264-65.

ment at Chattahoochee, given the character of the facility shown by the record, would hinder, rather than help, patients to recover.

The amici in this case can speak to this issue with authority. They include organizations of mental health professionals who have been extremely active for years in the establishment and administration of minimum professional standards for treatment, in and out of institutions.

The Joint Commission on Accreditation of Hospitals ("JCAH"), established by the American Medical Association, American Hospital Association, American College of Physicians, and American College of Surgeons, has organized Accreditation Councils responsible for setting minimum standards for both psychiatric facilities and facilities for the mentally retarded and evaluating such facilities. The Council on Accreditation of Psychiatric Facilities consists of most of the major organizations in this field, including the American Association on Mental Deficiency ("AAMD"), one of these amici, and the American Psychiatric Association, which is filing a separate amicus brief. The Council on Accreditation of Facilities for the Mentally Retarded includes three of these amici—AAMD, the American Psychological Association, and the National Association for Retarded Citizens —and also includes the American Psychiatric Association. These Accreditation Councils have published extensive standards for facilities for both the mentally ill[66] and the retarded,[67] the fruit of massive studies funded by HEW and the National Institute of Mental Health and years of experience evaluating institutional facilities and

[66] JCAH, ACCREDITATION MANUAL FOR PSYCHIATRIC FACILITIES (1972).

[67] JCAH, STANDARDS FOR RESIDENTIAL FACILITIES FOR MENTALLY RETARDED (1971).

programs.[68] The Accreditation Councils have teams of skilled evaluators engaged in the evaluation of these facilities for accreditation purposes. In addition, with the assistance of such organizations, the federal government has promulgated detailed minimum standards for facilities for the mentally retarded.[69] Moreover, the American Psychological Association, one of these amici, and the American Psychiatric Association have each published standards for care and treatment,[70] and they and other amici have published a number of position paper regarding the matter.[71]

Thus, the amici have had an enormous amount of experience in both the definition and the application of standards of treatment. It simply is not true that the right to treatment designed to cure or improve mental impairments is not susceptible to definition and enforcement. There are points of controversy, to be sure, but it is possible to mark out the uncontroversial minimum standards of acceptable professional practice with a considerable degree of precision.

[68] AAMD evaluated facilities for the mentally retarded from 1964 to 1971 and, along with other amici, continues to supply experts for JCAH evaluations.

[69] 39 Fed. Reg. 2219 (Jan. 17, 1974, effective March 18, 1974), *amending* 45 C.F.R. ch. II (Intermediate Care Facility Services). See especially 39 Fed. Reg. at 2226 *et seq.* (45 C.F.R. § 249.13).

[70] AMERICAN PSYCHOLOGICAL ASSOCIATION, STANDARDS FOR PROVIDERS OF PSYCHOLOGICAL SERVICES (1974); AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES (1974).

[71] *E.g.*, American Psychiatric Association Task Force on the Right to Care and Treatment, Position Paper on the Right to Adequate Care and Treatment for the Mentally Ill and Mentally Retarded (December 1974); American Psychiatric Association, *Position Paper on Involuntary Hospitalization of the Mentally Ill*, 130 AMERICAN JOURNAL OF PSYCHIATRY 3 (1973); National Association for Mental Health, Position Statement on the Right to Treatment (1970).

Obviously, courts should not be in the business of prescribing specific treatment for individual patients. But as has been noted elsewhere: [72]

> "[T]wo types of judicially manageable standards for the right to treatment have been developed. These standards, while calculated to ensure that the patient will receive adequate treatment, do not require a court to prescribe individualized therapeutic programs. The first type of standard pertains to institutional conditions; the court sets out basic minima applicable to all patients and necessary for any recovery of mental health. The second type of standard pertains to individual treatment programs; instead of itself prescribing therapies, however, the court, employing a scope of review similar to that used in reviewing administrative agency actions, examines a hospital's medical decisions to decide whether the expertise of the psychiatric profession has been properly utilized in a particular case and an *arguably* appropriate therapy prescribed." (Emphasis added.)

The first type of standard—minimum institutional standards—is illustrated by *Wyatt* v. *Stickney*.[73] In that case, which concerned treatment in Alabama institutions for both the mentally ill and the retarded, the district court found that three fundamental institutional conditions are prerequisites for adequate and effective individual therapy: (1) a "humane psychological and physical environment," (2) qualified staff "in numbers sufficient to administer adequate treatment," and (3)

[72] *Developments—Civil Commitment*, 87 HARV. L. REV. at 1337.

[73] 325 F. Supp. 781, 334 F. Supp. 1341 (M.D. Ala. 1971), 344 F. Supp. 373 & 387 (M.D. Ala. 1972), *aff'd in part sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir. Nov. 8, 1974).

"individualized treatment plans". 334 F. Supp. at 1343.[74] There is no responsible objection to these three fundamental standards, and there is a considerable degree of professional consensus regarding their detailed application.[75] In setting detailed standards implementing these three fundamental institutional prerequisites to treatment, the court was able to draw on the extensive experience of these amici in the establishment and administration of standards. With the aid of amici, the plaintiffs and the defendants were able to stipulate to

[74] *Accord*, *Welsch* v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974), involving residential facilities for the mentally retarded in Minnesota.

[75] *Developments—Civil Commitment*, 87 HARV. L. REV. at 1337-41:

> "The *Wyatt* court, recognizing that the milieu of the hospital can have detrimental rather than beneficial effects on the patient's mental health, found that humane conditions had to exist for hospitalization to be truly therapeutic. Standards for these conditions were reflected in the court's comprehensive order, which directed the hospitals to recognize patients' rights, *inter alia*, to enjoy privacy and dignity, to be free from physical restraint and isolation unless necessitated by emergency, to wear their own clothes, to keep personal posssesions, to be outdoors at regular and frequent intervals, to participate in religious worship, and to have suitable opportunities for social contact with the opposite sex. The hospitals were also ordered to provide certain physical conveniences such as a minimum amount of floor space per patient and a maximum ratio of patients to lavatory facilities.
>
> "The *Wyatt* order also reflected the belief that minimum staff-to-patient ratios were indispensable for adequate treatment. The court's standards were thus detailed and comprehensive . . . .
>
> " . . . .
>
> "As a final element of minimum institutional standards, the *Wyatt* injunction ordered that individual treatment plans be maintained for each patient. Such plans require the institution to focus its attention more precisely on the patients as individuals, rather than to rely on the commonly articulated theory that the mere presence of the patient in the 'therapeutic environment' of a mental hospital constitutes a 'milieu therapy.' . . ."

proper minimum standards to a considerable degree.[76] Where the plaintiffs and the defendants could not agree, the court could draw upon the considerable experience of the organizations representing the relevant professional disciplines in marking the outer boundaries of acceptable professional practice. Thus, there simply is no basis for the claim that it is not possible for a court to establish minimum institutional standards for adequate treatment.

Review of individual treatment does not present any greater difficulty. In the case now before the Court there was ample evidence that Donaldson received no treatment that could be considered adequate on any reasonable standard.[77] Thus, this case does not present any question as to standards with respect to the adequacy of individual treatment. We note, however, that courts have developed methods of reviewing individual treatment which do not require the court to engage in psychiatric evaluation and prescription. Thus, in *Tribby* v. *Cameron*, 379 F.2d 104 (D.C. Cir. 1966), the court held that it

[76] Memorandum of Agreement of Plaintiffs, Defendants and Amici Curiae American Orthopsychiatric Association, American Psychological Association and American Civil Liberties Union, filed Feb. 2, 1972, in *Wyatt* v. *Stickney*, Civ. Action No. 3195-N, M.D. Ala., N. Div'n.

[77] Respondent demonstrates in his brief the hollowness of petitioner's claim (Brief at 10) that Donaldson participated in milieu therapy, religious therapy, and recreational therapy. In spite of the criticisms that milieu therapy has evoked, see Halpern, *A Practicing Lawyer Views the Right to Treatment*, 57 GEO. L.J. 782, 786-87 (1969), amici acknowledge that milieu therapy is indeed a recognized form of therapy. Any therapy whose principal theme is inaction, however, is properly scrutinized by courts to ensure that "benign neglect" has not turned into simple neglect. Milieu therapy must be carefully designed with reference to the individual patient, and an attending physician should be keeping records and making frequent observations to ensure that the therapy is continuing to be a reasonable treatment plan. None of these precautions was taken in Donaldson's case.

could review an allegation that a mental institution was not providing the petitioner with any treatment, stating:

> "We do not suggest that the court should or can decide what particular treatment this patient requires. . . . We do not decide whether the [institution] has made the best decision, but only make sure that it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion." 379 F.2d at 105.

In *Williams* v. *Robinson*, 432 F.2d 637 (D.C. Cir. 1970), in which the petitioner sought to be placed in a less restrictive ward in a mental institution, the court indicated that while deference is due to administrative discretion, the court does have a duty to insure "that the hospital's expertise was actually brought into play." *Id.* at 641. As pointed out elsewhere, a court should not

> "interfere with the discretion of a hospital as long as the court could be convinced that the hospital was performing its duties by utilizing its expertise in the treatment of each patient. It thus appears that the judicial responsibility to adjudicate right to treatment claims can be reconciled with a court's desire to avoid possibly harmful judgments about the proper treatment to be provided mentally ill individuals." [78]

Thus, there is no danger that the right to treatment will require judges and juries "to second guess the judgment of trained physicians and psychologists concerning what constitutes 'adequate treatment'" (Petitioner's Brief at 30) any more than in convential malpractice cases in which courts and juries are not permitted to second guess professionals on matters as to which competent professionals may disagree, but instead are permitted

[78] *Developments—Civil Commitment*, 87 HARV. L. REV. at 1343-44.

only to predicate liability on departures from accepted professional practice.[79] Indeed, in damage cases under Section 1983, defendants are doubly protected because of the availability of the defense of good faith.[80] In view of that defense, individual liability for damages under Section 1983 will be *more* restricted than in conventional malpractice actions for improper treatment, brought under state law. In short, there is no basis whatever for the claim that the right to treatment is not capable of judicial definition and enforcement.

D. *Conclusion*

Amici strongly endorse the conclusion that in this case the jury was properly instructed that Donaldson, if not dangerous to himself or to others, had a constitutional right to treatment or release. In addition, amici believe that all involuntarily committed patients at state mental institutions, whether mentally ill or mentally retarded, whether dangerous or not, have a constitutional right to treatment as defined by the Court of Appeals below. The right to treatment may appropriately be administered by courts, with the aid of published standards and expert opinion on what constitutes minimally adequate treatment, beyond mere care and custody.

In addition, amici urge the Court not to assume or suggest that Donaldson would have been constitutionally confined had he been receiving proper treatment, and hope that the Court will expressly reserve the substantial constitutional question of the permissibility of committing individuals who are dangerous neither to themselves nor others and who can reasonably care for themselves outside an institution.

---

[79] See, *e.g.*, 1 D. LOUISELL & H. WILLIAMS, MEDICAL MALPRACTICE (1973) §§ 8.04-.06; R. SLOVENKO, PSYCHIATRY AND LAW (1973) 395 *et seq.*

[80] See Part I *supra*.

CONCLUSION

For the foregoing reasons, the judgment of the court below should be affirmed.

Respectfully submitted,

January 6, 1975

FRANCIS M. SHEA
RALPH J. MOORE, JR.
JOHN TOWNSEND RICH
734 Fifteenth Street, N.W.
Washington, D.C. 20005

Attorneys for Amici Curiae

MARCIA PEARCE BURGDORF
1238 North Eddy Street
South Bend, Indiana 46617

Attorney for the National Center for Law and the Handicapped and the National Association for Retarded Citizens

JAMES F. FITZPATRICK
1229 Nineteenth Street, N.W.
Washington, D.C. 20036

Attorney for the American Psychological Association

KURT W. MELCHIOR
One Embarcadero Center
San Francisco, Calif. 94111

HARRY J. RUBIN
P.O. Box 72
York, Pennsylvania 17405

Attorneys for the National Association for Mental Health

SHERIDAN L. NEIMARK
Munsey Building
Washington, D.C. 20004

Attorney for the National Society for Autistic Children

BEVERLEY ROWAN
1701 K Street, N.W.
Washington, D.C. 20036

Attorney for the Joseph P. Kennedy, Jr., Foundation

A. L. ZWERDLING
1211 Connecticut Avenue, N.W.
Washington, D.C. 20036

General Counsel, American Federation of State, County & Municipal Employees, AFL-CIO

SHEA & GARDNER
734 Fifteenth Street, N.W.
Washington, D.C. 20005

Of Counsel

Supreme Court, U. S.
FILED
JAN 6 1975
MICHAEL RODAK, JR., CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner,*

v.

KENNETH DONALDSON, *Respondent.*

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

E. BARRETT PRETTYMAN, JR.
ALLEN R. SNYDER
GAIL STARLING MARSHALL
HOGAN & HARTSON
815 Connecticut Avenue
Washington, D.C. 20006
Attorneys for Amicus Curiae American Psychiatric Association

PRESS OF BYRON S. ADAMS PRINTING, INC., WASHINGTON, D. C.

TABLE OF CONTENTS

	Page
INTEREST OF AMICUS CURIAE	1
CONSENT OF THE PARTIES	2
SUMMARY OF ARGUMENT	2
ARGUMENT	3
I. The Fourteenth Amendment Guarantees a Right to Treatment to Persons Involuntarily Committed to State Mental Institutions	3
A. Parens Patriae Commitments	5
B. Police Power Commitments	10
C. Elements of the Right to Treatment	18
II. Psychiatrists Employed at State Institutions Should Be Immune from Personal Liability for Damages When They Have Made a Good Faith Effort To Comply With Constitutional Requirements for Treatment	24
CONCLUSION	41

TABLE OF CITATIONS

CASES:	Page
Barr v. *Matteo*, 360 U.S. 564 (1959)	28
Baxstrom v. *Herold*, 383 U.S. 107 (1966)	4, 11
Board of Regents v. *Roth*, 408 U.S. 564 (1972)	4
Briscoe v. *Kusper*, 435 F.2d 1046 (7th Cir. 1970)	33
Clarke v. *Cady*, 358 F. Supp. 1156 (W.D. Wisc. 1973)	32
Collins v. *Schoonfeld*, 363 F. Supp. 1152 (D. Md. 1973)	32
Commonwealth v. *Page*, 339 Mass. 313, 159 N.E.2d 82 (1959)	9
Dobson v. *Cameron*, 383 F.2d 519 (D.C. Cir. 1967)	24
Doe v. *McMillan*, 412 U.S. 306 (1973)	28, 34
Donaldson v. *Florida*, 371 U.S. 806 (1962)	30
Donaldson v. *O'Connor*, 234 So. 2d 114 (Fla. 1969), *cert. denied*, 400 U.S. 869 (1970)	30
Donaldson v. *O'Connor*, 390 U.S. 971 (1968)	30
Dunn v. *Blumstein*, 405 U.S. 330 (1972)	17

Page

Eslinger v. *Thomas*, 476 F.2d 225 (4th Cir. 1973) 32
Francis v. *Resweber*, 329 U.S. 459 (1947) 17
Gaffney v. *Silk*, 488 F.2d 1248 (1st Cir. 1973) 29
Gregoire v. *Biddle*, 177 F.2d 579 (2d Cir. 1949) 35
Haines v. *Kerner*, 492 F.2d 937 (7th Cir. 1974) 32
Handverger v. *Harvill*, 479 F.2d 513 (9th Cir.), *cert. denied*, 414 U.S. 1072 (1973) 33
Harrison v. *Brooks*, 446 F.2d 404 (1st Cir. 1971) 33
Hawaii v. *Standard Oil Co.*, 405 U.S. 251 (1972) 5
Humphrey v. *Cady*, 405 U.S. 504 (1972) 4
In re Ballay, 482 F.2d 648 (D.C. Cir. 1973) 4, 6
In re Donaldson, 364 U.S. 808 (1960) 30
In re Gault, 387 U.S. 1 (1967) 7, 15
In re Oakes, 8 Law Rep. 122 (Mass. 1845) 6
In re Winship, 397 U.S. 358 (1970) 3
Jackson v. *Indiana*, 406 U.S. 715 (1972) 4, 8, 17
Jannetta v. *Cole*, 493 F.2d 1334 (4th Cir. 1974) 33
Jones v. *Perrigan*, 459 F.2d 81 (6th Cir. 1972) 33
Kent v. *United States*, 383 U.S. 541 (1966) 7, 9
Korematsu v. *United States*, 323 U.S. 214 (1944) 15
McNeil v. *Director*, 407 U.S. 245 (1972) 4, 7
Meyer v. *Nebraska*, 268 U.S. 390 (1923) 4
Miller v. *Overholser*, 206 F.2d 415 (D.C. Cir. 1953) ... 14
Mitchell v. *Boslow*, 357 F. Supp. 199 (D. Md. 1973) ... 33
Nason v. *Superintendent*, 353 Mass. 604, 233 N.E.2d 908 (1968) 9
Nebbia v. *New York*, 291 U.S. 502 (1934) 4
People ex rel. Anonymous v. *La Burt*, 14 App. Div. 2d 560, 218 N.Y.S.2d 738 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962) 30
Pierson v. *Ray*, 386 U.S. 547 (1967) 28, 29, 31
Powell v. *Texas*, 392 U.S. 514 (1968) 12, 18
Prince v. *Massachusetts*, 321 U.S. 158 (1944) 6
Ragsdale v. *Overholser*, 281 F.2d 943 (D.C. Cir. 1960) 9
Ricks v. *District of Columbia*, 414 F.2d 1097 (D.C. Cir. 1968) 14
Roberts v. *Williams*, 456 F.2d 819 (5th Cir.), *cert. denied*, 404 U.S. 866 (1971) 29
Robinson v. *California*, 370 U.S. 660 (1962) 14, 17
Rouse v. *Cameron*, 373 F.2d 451 (D.C. Cir. 1966) 8, 22, 23, 27, 37

Page

Sas v. *Maryland*, 334 F.2d 506 (4th Cir. 1964) 14
Scheuer v. *Rhodes*, 416 U.S. 232 (1974) 28
Schmidt v. *Wingo*, 499 F.2d 70 (6th Cir. 1974), *affirming* 368 F. Supp. 727 (W.D. Ky. 1973) 34
Silber v. *United States*, 370 U.S. 717 (1962) 28
Skinner v. *Spellman*, 480 F.2d 539 (4th Cir. 1973) 32
Smith v. *Losee*, 485 F.2d 334 (10th Cir. 1973) (en banc) 34
Stachulak v. *Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973) 37
Strickland v. *Inlow*, 485 F.2d 186 (8th Cir. 1973), *cert. granted sub nom. Wood* v. *Strickland*, 94 S.Ct. 1932 (No. 73-1285, Apr. 15, 1974) 33
Tribby v. *Cameron*, 379 F.2d 104 (D.C. Cir. 1967) 23
United States v. *Atkinson*, 297 U.S. 157 (1936) 28
Weber v. *Aetna Casualty & Surety Co.*, 406 U.S. 164 (1972) 17
Welsch v. *Likins*, 373 F. Supp. 487 (D. Minn. 1974) ..8, 37
Westberry v. *Fisher*, 309 F. Supp. 12 (D. Me. 1970) .. 29
Whitree v. *State*, 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968) 37
Williamson v. *Lee Optical Co.*, 348 U.S. 483 (1955) ... 4
Williamson v. *United States*, 184 F.2d 280 (2d Cir. 1950) 14
Winters v. *Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) 6
Wood v. *Strickland*, 94 S.Ct. 1932 (No. 73-1285, *cert. granted* Apr. 15, 1974) 29
Wyatt v. *Aderholt*, No. 72-2634 (5th Cir., Nov. 8, 1974) 8, 13, 15, 19, 36, 37
Wyatt v. *Stickney*, 325 F. Supp. 781 (M.D. Ala.), *enforced* 334 F. Supp. 1341 (M.D. Ala. 1971), *and* 344 F. Supp. 373, 387 (M.D. Ala. 1972) *affirmed in part and remanded in part sub nom. Wyatt* v. *Aderholt*, No. 72-2634 (5th Cir., Nov. 8, 1974) 8, 19, 21, 22, 27, 30

MISCELLANEOUS:

AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW (rev. ed. 1971) 5
AMERICAN PSYCHIATRIC ASSOCIATION, CLINICAL ASPECTS OF THE VIOLENT INDIVIDUAL (Task Force Rep. No. 8, 1974) 11

Page

AMERICAN PSYCHIATRIC ASSOCIATION, POSITION PAPER ON THE RIGHT TO ADEQUATE CARE AND TREATMENT FOR THE MENTALLY ILL AND MENTALLY RETARDED (4th Draft, Oct. 19, 1974) 21
American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIAT. 1458 (1967) 6, 10, 39
AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITAL AND CLINICS (rev. ed. 1958) 22, 26
AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES (rev. ed. 1974) 21
Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960) 30, 36
Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623 (1971) 36
H. BRILL & B. MALZBERG, MENTAL HOSPITAL SERVICE (APA) (Supp. No. 153, 1962) 10
Case Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment*, 86 HARV. L. REV. 1282 (1973) 5, 16
23 D.C. CODE §§ 1322-23 (Supp. I, 1974) 15
Dershowitz, *Imprisonment by Judicial Hunch*, 57 A.B.A.J. 560 (1971) 15
Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways*, 4 TRIAL 29 (Feb.-Mar. 1968) 7
Developments in the Law, Civil Commitment of the Mentally Ill, 87 HARV. L. REV. 1190 (1974) ...3, 6, 8, 17
Farina & Ring, *The Influence of Perceived Mental Illness on Interpersonal Relations*, 70 J. ABNORMAL PSYCHOL. 47 (1965) 3
Gilboy & Schmidt, *"Voluntary" Hospitalization of the Mentally Ill*, 66 NW. U.L. REV. 429 (1971) 5
Giovani & Gureal, *Socially Disruptive Behavior of Ex-Mental Patients*, 17 ARCH. GEN. PSYCHIAT. 146 (1967) 10
82 HARV. L. REV. 1771 (1969) 37
Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary, 91st Cong., 1st & 2d Sess. (1969-1970) 3
JOINT INFORMATION SERVICE, AMERICAN PSYCHIATRIC ASS'N & NAT'L ASS'N FOR MENTAL HEALTH, ELEVEN INDICES (1971) 26
Mitchell, *Bail Reform and the Constitutionality of Pre-Trial Detention*, 55 VA. L. REV. 1223 (1969)..... 15

Page

Morris, *The Confusion of Confinement Syndrome*, 17 BUFF. L. REV. 651 (1968).....11, 16
Morse, *Tort Liability of the Psychiatrist*, 18 SYR. L. REV. 691 (1967) 37
NAT'L INST. MENTAL HEALTH, STAFFING OF MENTAL HEALTH FACILITIES, UNITED STATES, 1972 (DHEW Pub. No. ADM 74-28, 1974) 25
NAT'L INST. MENTAL HEALTH, STATISTICAL NOTE 109, STAFFING OF STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, 1973 (Aug., 1974) 26
Note, *Civil Commitment of the Mentally Ill: Theories and Procedures*, 79 HARV. L. REV. 1288 (1966) 5
Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L. J. 87 (1967) 7
Note, *The Nascent Right to Treatment*, 53 VA. L. REV. 1134 (1967) 5
Note, *Preventive Detention: An Empirical Analysis*, 6 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 291 (1971) 15
Note, *The Rights of the Mentally Ill During Incarceration: The Developing Law*, 25 U. FLA. L. REV. 494 (1973) 7
Postel, *Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1 (1971) 7
Project, *Civil Commitment of the Mentally Ill*, 14 U.C.L.A. L. REV. 822 (1967) 7
W. PROSSER, HANDBOOK OF THE LAW OF TORTS (3d ed. 1964) 23
J. RAPPEPORT, THE CLINICAL EVALUATION OF DANGEROUSNESS OF THE MENTALLY ILL (1967) 10, 11
Rosen, *Detection of Suicidal Patients: An Example of Some Limitations on the Prediction of Infrequent Events*, 18 J. CONSULT. PSYCHOL. 397 (1954) 10
Sarbin & Mascuso, *Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness*, 35 J. CONSULT. PSYCHOL. 159 (1970) 3
Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237 (1974) 6
Solomon, *The American Psychiatric Association in Relation to American Psychiatry*, 115 AM. J. PSYCHIAT. 1 (1958) 27
Tribe, *An Ounce of Detention: Preventive Justice in the World of John Mitchell*, 56 VA. L. REV. 371 (1970) 15

IN THE

Supreme Court of the United States

OCTOBER TERM, 1974

No. 74-8

J. B. O'CONNOR, M.D., *Petitioner,*

v.

KENNETH DONALDSON, *Respondent.*

BRIEF OF AMERICAN PSYCHIATRIC ASSOCIATION AS AMICUS CURIAE

INTEREST OF AMICUS CURIAE

The American Psychiatric Association (A.P.A.), founded in 1844, is the nation's largest organization of qualified doctors of medicine who specialize in psychiatry. Over 21,000 of the nation's approximately 25,000 psychiatrists are members of the Association. The A.P.A. has participated as an amicus curiae numerous times in cases throughout the country involving mental health issues.

Amicus believes this case to be of historic importance to the future of mental health care in the nation's public mental institutions. The landmark ruling below that there is a constitutional right to treatment—and the difficult question of how to enforce that right—are of immense concern to members of the A.P.A. and to their patients.

CONSENT OF THE PARTIES

Amicus is filing this Brief with the consent of both parties, whose letters of consent have been filed with the Clerk.

SUMMARY OF ARGUMENT

1. Amicus Curiae American Psychiatric Association, whose members always have worked to implement the right of psychiatric patients to receive adequate care and treatment, wholeheartedly endorses the decision below that the Constitution requires states to provide meaningful treatment when they institutionalize mentally ill citizens. Civil commitment of the mentally ill results in deprivation of the precious right to liberty itself. Thus, due process of law requires that states in fact provide the treatment which they promise when asserting a governmental interest to justify such commitment. When that promise is broken, and "treatment" turns into neglect, the supposedly benevolent purpose of the commitment becomes a cruel hoax, masking the violation of these citizens' fundamental constitutional rights.

2. To enforce this constitutional right to treatment, courts should require states to supply sufficient resources to give each patient a realistic opportunity to receive adequate treatment. Individual doctors employed at these institutions should have a constitutional duty to try in good faith to devote their professional skill to the best possible treatment for each of their patients. When the institutions' resources are inadequate, however, doctors who have tried in good faith to treat their patients should not be personally liable in damages to those patients who received insufficient treatment. To hold the doctor rather than the institution liable in such cases will deter psychiatrists

from working at the institutions where they are most needed—those where the current level of treatment is most inadequate—and will seriously jeopardize enforcement of the patients' right to treatment.

ARGUMENT

I. THE FOURTEENTH AMENDMENT GUARANTEES A RIGHT TO TREATMENT TO PERSONS INVOLUNTARILY COMMITTED TO STATE MENTAL INSTITUTIONS.

When the state confines a citizen in a mental institution involuntarily, the state's action affects some of the most basic rights protected by the Constitution. For what is usually an indefinite period of time,[1] the citizen loses his or her liberty—an interest of "transcending value." *In re Winship*, 397 U.S. 358, 364 (1970). Not only do committed citizens lose all freedom of movement, privacy, and association, but most states also strip away their basic civil rights, such as the rights to vote, serve on juries, make a contract, or keep custody of their own children.[2] Moreover, former mental patients are often stigmatized by a society which still too frequently demonstrates an "irrational fear of the mentally ill."[3] Such stigmatization can

---

[1] *See Developments in the Law, Civil Commitment of the Mentally Ill*, 87 HARV. L. REV. 1190, 1193 (1974) (hereinafter, "*Developments*").

[2] *Id.* at 1198-99.

[3] *Hearings on Constitutional Rights of the Mentally Ill Before the Subcomm. on Constitutional Rights of the Senate Comm. on the Judiciary*, 91st Cong., 1st & 2d Sess. 62-63 (1969-1970) (testimony of Dr. Morton Birnbaum). *See generally* Farina & Ring, *The Influence of Perceived Mental Illness on Interpersonal Relations*, 70 J. ABNORMAL PSYCHOL. 47 (1965) (people thought to be mentally ill viewed unfavorably although their behavior is normal); Sarbin & Mascuso, *Failure of a Moral Enterprise: Attitudes of the Public Toward Mental Illness*, 35 J. CONSULT. PSYCHOL. 159, 162 (1970) (public considers the mentally ill dirty, worthless, and dangerous).

itself constitute a deprivation of liberty in the constitutional sense. *See Board of Regents* v. *Roth,* 408 U.S. 564, 573 (1972).

Thus, this Court has recognized that civil commitment of the mentally ill involves a "massive curtailment of liberty." *Humphrey* v. *Cady,* 405 U.S. 504, 509 (1972). It affects "fundamental rights," *see Baxstrom* v. *Herold,* 383 U.S. 107, 113 (1966), which are encompassed by the Due Process Clause of the Fourteenth Amendment. *In re Ballay,* 482 F.2d 648, 655 (D.C. Cir. 1973).

It is well established that governmental actions affecting such constitutionally protected interests must bear at least a rational relationship to legitimate state ends. *Williamson* v. *Lee Optical Co.,* 348 U.S. 483, 491 (1955); *Nebbia* v. *New York,* 291 U.S. 502, 525 (1934); *Meyer* v. *Nebraska,* 262 U.S. 390 (1923). The Court has made clear that this principle applies to procedures for the involuntary confinement of the mentally ill or disabled. *Jackson* v. *Indiana,* 406 U.S. 715, 738 (1972):

> At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed.

See also McNeil v. *Director,* 407 U.S. 245, 250 (1972) (duration of confinement "must be strictly limited" in accord with state's purpose for commitment); *Humphrey* v. *Cady, supra,* 405 U.S. at 514 (allegation that no psychiatric treatment provided after commitment under Sex Crimes Act presents "substantial constitutional claims").

The court below identified two basic state purposes for civil commitment of the mentally ill—a *"parens patriae"* rationale, *i.e.,* to benefit the person committed; and a "police power" rationale, *i.e.,* to protect society from dangerous individuals. 493 F.2d at 521.[4] Under either rationale, involuntarily committed mental patients[5] have a constitutional right to psychiatric treatment.

A. Parens Patriae Commitments

The *parens patriae* power generally refers to the state's power to serve "as guardian of persons under legal disabilities to act for themselves." *Hawaii* v. *Standard Oil Co.,* 405 U.S. 251, 257 (1972). It has served to justify special restrictions on the rights of

---

[4] *See* Note, *Civil Commitment of the Mentally Ill: Theories and Procedures,* 79 HARV. L. REV. 1288, 1289-97 (1966); Note, *The Nascent Right to Treatment,* 53 VA. L. REV. 1134, 1138-39 (1967); Case Comment, *Wyatt* v. *Stickney and the Right of Civilly Committed Mental Patients to Adequate Treatment,* 86 HARV. L. REV. 1282, 1288-91 (1973).

Typically, state statutes recognize three separate criteria for commitment of the mentally ill: need for care or treatment (*parens patriae*), danger to others (police power), and danger to self (predominantly *parens patriae,* but arguably also police power to the extent that the state is acting to prevent the crime of suicide). An American Bar Foundation study in 1971 reported that danger to self or others was the sole criterion for commitment in nine states; need for care or treatment was the sole basis in six other states; 18 additional states include both criteria as alternative bases; and the remaining states enumerate no statutory criteria. AMERICAN BAR FOUNDATION, THE MENTALLY DISABLED AND THE LAW 36-49 (rev. ed. 1971), *cited in Jackson* v. *Indiana,* 406 U.S. 715, 737 n.19 (1972).

[5] While Amicus believes that there generally may be little practical distinction between "voluntarily" and "involuntarily" committed patients, and that all patients should receive adequate psychiatric treatment, the constitutional principles discussed here apply only when the state acts to deprive citizens of liberty against their will. *See generally* Gilboy & Schmidt, *"Voluntary" Hospitalization of the Mentally Ill,* 66 NW. U.L. REV. 429, 452 (1971).

children, such as compulsory school attendance laws.[6] Application of the doctrine to commitment of the mentally ill dates back at least to an 1845 opinion of the Massachusetts Supreme Judicial Court, which authorized the commitment of a nonviolent individual on the theory that it was "conducive" to restoration of his sanity. *In re Oakes*, 8 Law Rep. 122, 125 (Mass. 1845). Thus, even where an individual poses no danger to society, frequently a state will invoke the *parens patriae* rationale to justify commitment for "treatment which it believes will be in the best interests of the person." *In re Ballay, supra*, 482 F.2d at 658.[7]

[6] *See, e.g., Prince* v. *Massachusetts*, 321 U.S. 158, 166 (1944) ("Acting to guard the general interest in youth's well-being the state as *parens patriae* may . . . requir[e] school attendance.").

[7] The *parens patriae* rationale might be thought to imply that the involuntarily committed mental patient not only has a *right* to treatment, but also has a *duty to accept* treatment that the state is providing for the patient's own good. *See generally Developments* 1344-51. Nevertheless, Amicus believes that recognition of the right to treatment is not inconsistent with allowing most patients a right to refuse treatment. In the overwhelming majority of cases, cooperation of the patient is essential to meaningful psychiatric therapy. *See* American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIAT. 1458, 1459 (1967) (comprehensive treatment plan requires patient cooperation). Moreover, forcing treatment on unwilling patients may run afoul of important First Amendment principles. *See Winters* v. *Miller*, 446 F.2d 65 (2d Cir.), *cert. denied*, 404 U.S. 985 (1971) (involuntarily committed Christian Scientist has right to refuse medication treatment). *See generally* Shapiro, *Legislating the Control of Behavior Control: Autonomy and the Coercive Use of Organic Therapies*, 47 S. CAL. L. REV. 237 (1974). A rule accommodating these possibly conflicting considerations might allow the state to commit a patient for a limited time, while the physician sought to convince the patient to accept needed treatment. If, however, the patient continued to refuse treatment, and if the patient had not been judicially declared incompetent, long-term *parens patriae* commitment could not be justified, and release would be required. *See* Note, *The Rights of the Mentally Ill During Incarceration: The Developing Law*, 25 U. FLA. L. REV. 494, 504-05 (1973); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 YALE L.J. 87, 112-13 (1967). *See also McNeil* v. *Director*, 407 U.S. 245 (1972).

Arguably, such a temporary deprivation of liberty, when accompanied by adequate treatment for a mental disability, may serve to restore the citizen's meaningful, long-term liberty.

Whatever the limits of the *parens patriae* doctrine,[8] at the very least, when a state involuntarily confines one of its mentally ill citizens to an institution on the ground that it is acting in a humanitarian way pursuant to its *parens patriae* power to aid that individual, due process requires that the individual in fact be given such aid and treatment as would be reasonably calculated to benefit or cure the citizen. Since the state's asserted purpose for a *parens patriae* commitment[9] is to provide treatment,[10] "due process requires

[8] *See In re Gault*, 387 U.S. 1, 13 (1967) (meaning of *parens patriae* rationale is "murky"); *Kent* v. *United States*, 383 U.S. 541, 555 (1966) (*parens patriae* philosophy of the juvenile court "is not an invitation to procedural arbitrariness"). Indeed, some commentators argue that *parens patriae* commitments should be limited to cases where the court makes a finding of *incapacity*, rather than simply mental illness. *See, e.g.*, Dershowitz, *Psychiatry in the Legal Process: A Knife That Cuts Both Ways*, 4 TRIAL 29, 32 (Feb.-Mar. 1968); Postel, *Civil Commitment: A Functional Analysis*, 38 BROOKLYN L. REV. 1, 33-37 (1971); Project, *Civil Commitment of the Mentally Ill*, 14 U.C.L.A.L. REV. 822, 830 (1967).

[9] In many commitments, of course, the state asserts *both* a *parens patriae* and police power purpose. *See* p. 11, *infra*.

[10] In cases of mentally ill individuals who are totally unable to care for themselves, or who may be dangerous to themselves, a state might assert a *parens patriae* interest simply in providing safe, custodial care, even if the individual's illness might not be curable. This justification is inapplicable to the instant case, of

that the nature and duration of commitment bear some reasonable relation to" that purpose. *Jackson* v. *Indiana, supra,* 406 U.S. at 738.

As the court noted in *Wyatt* v. *Stickney,* 325 F. Supp. 781, 785 (M.D. Ala.), *enforced,* 334 F. Supp. 1341 (M.D. Ala. 1971), *and* 344 F. Supp. 373, 387 (M.D. Ala. 1972), *aff'd in part and remanded in part sub nom. Wyatt* v. *Aderholt,* No. 72-2634 (5th Cir., Nov. 8, 1974):

> To deprive any citizen of his or her liberty upon the altruistic theory that the confinement is for humane therapeutic reasons and then to fail to provide adequate treatment violates the very fundamentals of due process.

Accord, Welsch v. *Likins,* 373 F. Supp. 487 (D. Minn. 1974). *See also Rouse* v. *Cameron,* 373 F.2d 451 (D.C. Cir. 1966) (dictum).

This Court, too, has emphasized that a curtailment of liberty can only be justified where the "theoretical purpose" embodied in the *parens patriae* rationale is matched by "actual performance":

> While there can be no doubt of the original laudable purpose of juvenile courts, studies and critiques in recent years raise serious questions as to whether actual performance measures well enough against theoretical purpose to make tolerable the immunity . . . from the reach of constitutional guaranties. . . . There is much evidence that some juvenile courts . . . lack the personnel, facilities and techniques to perform adequately as representatives of the State in a *parens patriae* capacity. [*Kent* v. *United States,* 383 U.S. 541, 555-56 (1966).]

Accord, e.g., Nason v. *Superintendent,* 353 Mass. 604, 612, 233 N.E.2d 908, 913 (1968) ("remedial aspect of confinement [must] have foundation in fact").

When treatment is not provided, a hospital is transformed "into a penitentiary where one could be held indefinitely for no convicted offense." *Ragsdale* v. *Overholser,* 281 F.2d 943, 950 (D.C. Cir. 1960). Such confinement bears no relation to the state's asserted purpose for a *parens patriae* commitment. In *Commonwealth* v. *Page,* 339 Mass. 313, 159 N.E.2d 82 (1959), the petitioner was civilly committed to a treatment center for sexual offenders on the day before his criminal sentence was to end. However, because the treatment center was not fully constructed, he was returned to the prison where he received only the same group and individual therapy as the general prison population. The court released the petitioner on habeas corpus, holding (339 Mass. at 317-18, 159 N.E.2d at 85) (emphasis added):

> [T]o be sustained as a nonpenal statute, in its application to the defendant, it is necessary that the remedial aspect of confinement thereunder have foundation in fact. It is not sufficient that the Legislature announce a remedial purpose if the consequences to the individual are penal. While we are not now called upon to state the standards

course, since it was not the basis of Mr. Donaldson's commitment. *See* 493 F.2d at 517, 521. Moreover, in such instances due process would require, at the very least, that a) at the commitment hearing the state assert *and prove* this narrower rationale for confinement, without reliance on any alleged treatment benefits to justify the commitment; and b) that the duration of the commitment be strictly limited to the period during which the patient is unable to care for himself or herself. *See Developments* 1221-22. *But see Wyatt* v. *Aderholt,* No. 72-2634, slip op. at 712 (5th Cir., Nov. 8, 1974) (while "need for care" may be rational state interest, mere care, without treatment, does not outweigh massive curtailment of liberty involved in involuntary commitment).

which such a center must observe to fulfill its remedial purpose, we hold that a *confinement in a prison which is undifferentiated from the incarceration of convicted criminals is not remedial so as to escape constitutional requirements of due process.*

In the instant case, the lower courts have found that Mr. Donaldson was not a dangerous individual, and that his commitment was justified by the state solely on the *parens patriae* rationale that he was in need of treatment. 493 F.2d at 517, 521. Under such circumstances, the state's continued long-term confinement of Donaldson, without providing the medical treatment alleged to be the basis of that confinement, was arbitrary state action, depriving Donaldson of his liberty without due process of law.

B. Police Power Commitments

The state's police power has also been suggested as a rationale for commitment of mentally ill individuals who are found to be dangerous to society. Amicus believes that in fact very few of the mentally ill present such a danger.[11] In addition, the psychiatric community cannot assure this Court that there are any highly

[11] At least ninety percent of patients in American mental hospitals are considered harmless to others. *See* American Psychiatric Association, *supra* note 7, at 1459. *See also* H. Brill & B. Malzberg, Mental Hospital Service (APA) (Supp. No. 153, 1962) (sample crime rate before commitment and after release a fraction of that of the general population); J. Rappeport, The Clinical Evaluation of the Dangerousness of the Mentally Ill (1967); Giovanni & Gureal, *Socially Disruptive Behavior of Ex-Mental Patients,* 17 Arch. Gen. Psychiat. 146, 153 (1967); Rosen, *Detection of Suicidal Patients: An Example of Some Limitations on the Prediction of Infrequent Events,* 18 J. Consult. Psychol. 397 (1954).

reliable techniques for identifying with certainty which of the mentally ill fall into this minority category of dangerous individuals.[12] Amicus recognizes that the truly dangerous mentally ill pose special problems for society, not only for the legal system, but also for mental health care personnel in that these individuals often are the most resistant to treatment.[13] Nevertheless, whenever the state acts under its police power to deprive a mentally ill person of liberty on the basis of a *prediction* of dangerousness, rather than a finding that the person has committed a criminal act, Amicus believes that the state should provide that person with psychiatric treatment for his mental illness.

It should be emphasized at the outset that a state can not avoid the constitutional requirement of a rational relation to its *parens patriae* purpose of commitment, discussed in Part A, *supra,* merely by verbalizing the additional purpose of protection of society. Any time the state relies at all on a *parens patriae* rationale for confinement, the concomitant constitutional right to treatment discussed above attaches to the person who is the object of such confinement. Where the precise basis in a particular case cannot be determined, the presumption should be that the state was acting at least in part for the benefit of the mentally ill patient pursuant to its *parens patriae* powers.

[12] Studies on "dangerous" mental patients released following *Baxstrom* v. *Herold,* 383 U.S. 107 (1966), indicate that very few of the patients who were released, and who psychiatrists predicted would commit violent crimes, did in fact commit those crimes. *See, e.g.,* Morris, *The Confusion of Confinement Syndrome,* 17 Buff. L. Rev. 651 (1968); for studies on similar groups, *see, e.g.,* J. Rappeport, *supra* note 11.

[13] American Psychiatric Association, Clinical Aspects of the Violent Individual (Task Force Rep. No. 8, 1974).

However, even if the state could establish that benefit to the patient *(parens patriae)* formed no part of its rationale for interference with liberty, but rather that its sole purpose (to which the nature of its confinement need be constitutionally related) was protection of society, there are still severe constitutional problems in involuntary commitment absent an attendant *bona fide* effort to provide adequate treatment. Indeed, such an argument by the state amounts to the assertion that *preventive detention* of the mentally ill for an indeterminate term without treatment is constitutionally permissible.

In addition to holding that a constitutional right to treatment exists for mental patients committed by the state pursuant to a *parens patriae* rationale, the court below alternatively held that due process requires the state to provide treatment as a *quid pro quo* to the civilly committed mental patient, regardless of whether the commitment was under a *parens patriae* or police power rationale. 493 F.2d at 521-525. This statement of the constitutional right to treatment, which also derives from the Due Process Clause of the Fourteenth Amendment, begins with the recognition that long-term detention under our system of justice is generally predicated upon (1) a finding in an adversary proceeding with the full panoply of constitutional limitations and rights, (2) that an individual has committed a specific act defined as an offense against the state, (3) for which a maximum period of detention is explicitly prescribed. *Id.* at 522, *citing Powell* v. *Texas*, 392 U.S. 514, 533, 542-43 (1968). The court below reasoned that whenever the state seeks long-term detention outside of these "three central limitations on the government's power to detain," due process requires that the government provide to the

detained individual some *quid pro quo*—such as beneficial treatment—to justify confinement.

It should be noted that this requirement of a *quid pro quo* as expressed by the court below is deemed to derive from the *substantive nature* of civil commitment as a form of preventive detention, and not merely from the fact that such detention lacks certain procedural safeguards. *See* 493 F.2d at 522 n.21. The right as formulated by the Court of Appeals would appear to be unaffected by, for example, a state procedure whereby indefinite commitment was permitted upon a finding in an adversary proceeding, with full Bill of Rights safeguards, that an individual was "dangerous to others." For even in such a context, the state would still be acting outside two of the above-enumerated "three central limitations on the government's power to detain." Thus, even where the justification for detention is dangerousness to society, if the government wishes to bypass awaiting the effectuation of a specific criminal offense and the adjudication of guilt, with full Bill of Rights protection for the accused, it must offer in return a *quid pro quo*, and rehabilitative treatment is the most commonly recognized form of such an exchange.[14]

Although there is no direct judicial antecedent for this particular formulation of the limitations on the state's right of confinement, close judicial analogy can be found. For example, statutes which attempt to bypass the third requirement—detention limited to a fixed term—have been closely scrutinized by the judiciary

[14] Or, as the Fifth Circuit later restated its *Donaldson* holding, treatment must be provided as the *quid pro quo* society owes for the extra safety it derives from the denial of individuals' liberty. *Wyatt* v. *Aderholt*, *supra*, slip op. at 726.

for some form of therapeutic or humanitarian benefit. In examining indeterminate commitment under the Maryland Defective Delinquent Statute, the Fourth Circuit noted:

> For those in the category . . . it [the statute] would substitute psychiatric treatment for punishment in the conventional sense and would free them from confinement, not when they have "paid their debt to society", but when they have been sufficiently cured to make it reasonably safe to release them. With this humanitarian and progressive approach to the problem, no person who has deplored the inadequacies of conventional penological practices can complain. . . . [However,] deficiencies in staff, facilities and finances would undermine the efficacy of the Institution and the justification for the law, and ultimately the constitutionality of its application. [*Sas* v. *Maryland*, 334 F.2d 506, 517 (4th Cir. 1964).]

See also Miller v. *Overholser*, 206 F.2d 415, 419 (D.C. Cir. 1953) (indefinite commitment under sexual psychopath law justifiable only upon theory of therapeutic treatment); *cf. Robinson* v. *California*, 370 U.S. 660, 666 (1962) (status as drug addict does not meet criterion of commission of specific offense, justifying long-term detention; but "compulsory treatment" might be such a justification); *Ricks* v. *District of Columbia*, 414 F.2d 1097, 1110 (D.C. Cir. 1968) ("Statistical likelihood that a particular societal segment will engage in criminality is not . . . [a] substitute for proof of individual guilt"); *Williamson* v. *United States*, 184 F.2d 280, 282 (2d Cir. 1950) (Jackson, Circuit Justice) ("Imprisonment to protect society from predicted but unconsummated offenses is so unprecedented in this country and so fraught with danger of

excesses and injustice that I am loath to resort to it . . . .").[15]

Even under emergency war-time conditions, this Court has held that exclusion from the area in which one's home is located and constant confinement between the hours of 8:00 p.m. and 6:00 a.m. can be constitutionally justified by "[n]othing short of apprehension by the proper military authorities of the gravest imminent danger to the public safety." *Korematsu* v. *United States*, 323 U.S. 214, 218 (1944) (upholding temporary detention of citizens of Japanese ancestry justified as necessary to prevent espionage and sabotage).

When the state acts under its police powers to detain individuals *full-time* in state institutions for *indefinite periods* of time, "then treatment ha[s] to be provided as the *quid pro quo* society ha[s] to pay as the price of the extra safety it derive[s] from the denial of individuals' liberty." *Wyatt* v. *Aderholt*, *supra*, slip op. at 726. *Compare In re Gault*, 387 U.S. 1, 22-23 n.30 (1967):

> While we are concerned only with procedure before the juvenile court in this case, it should be noted that to the extent that the special procedures

[15] Enactment of the preventive detention aspects of the D.C. Bail Reform Act, 23 D.C. Code §§ 1322-23 (Supp. I, 1974), has caused much scholarly debate. Although, as in civil commitment, detention of arrestees under the statute is based on predictions of dangerousness, an adversary hearing is provided and detention is strictly limited to 60 calendar days. *See, e.g.*, Note, *Preventive Detention: An Empirical Analysis*, 6 HARV. CIV. RIGHTS-CIV. LIB. L. REV. 291 (1971); Dershowitz, *Imprisonment by Judicial Hunch*, 57 A.B.A.J. 560 (1971); Tribe, *An Ounce of Detention: Preventive Justice in the World of John Mitchell*, 56 VA. L. REV. 371 (1970); cf. Mitchell, *Bail Reform and the Constitutionality of Pre-Trial Detention*, 55 VA. L. REV. 1223 (1969).

> for juveniles are thought to be justified by the special consideration and treatment afforded them, there is reason to doubt that juveniles always receive the benefits of such a *quid pro quo*.

Thus, Amicus urges this Court to recognize a constitutional right to treatment as the *quid pro quo* society offers for the massive curtailment of liberty extracted in involuntary civil commitment.

Finally, it should be noted that in addition to the *quid pro quo* approach of the court below, there are other difficult constitutional questions concerning involuntary commitment without treatment. First, would not the confining of the mentally ill because of their "dangerous propensities" violate the Equal Protection Clause, in that others with the same propensities are not subject to involuntary confinement? If the interest which justifies making only the mentally ill liable to confinement is the need to protect society, then the classification is both overinclusive, in that most mentally ill are not dangerous,[16] and underinclusive, in that many non-mentally ill are potentially dangerous. Case Comment, *supra* note 4, at 1294. Furthermore, the legislature in singling out a specific subgroup for invidious treatment must show at the very least a rational basis for such discrimination. The only rationale for sequestering dangerous mentally ill individuals, while not seeking confinement of dangerous individuals who are not mentally ill, is the belief that the dangerous propensities of the mentally ill can be the subject of treatment and/or preventive cure.[17] This rationale,

[16] *See* note 11, *supra*.

[17] An alternative argument—that mental illness is a particularly good predictor of dangerousness—simply does not square with the facts. *See* note 11, *supra*. *See also* Morris, *supra* note 12.

of course, fails if adequate treatment is not in fact provided, as there is no "rational relation" between the nature of the confinement and the classification on which it is based. *Cf. Jackson* v. *Indiana, supra,* 406 U.S. at 738. Indeed, since civil commitment affects fundamental interests which are accorded explicit constitutional protection, such as physical freedom, privacy, association, and sometimes the right to vote, the state's classifications in this area should be subject to stricter judicial scrutiny than the requirement of merely a "rational" relationship to the state's interest. *Developments* 1215 & n.83; *see, e.g., Weber* v. *Aetna Casualty & Surety Co.,* 406 U.S. 164 (1972); *Dunn* v. *Blumstein,* 405 U.S. 330, 335 (1972).

Second, if the *quid pro quo* right to treatment discussed above is not sustained, this Court will have to decide whether confining the mentally ill under the police power for their dangerous propensities, without providing adequate treatment, constitutes cruel and unusual punishment under the Eighth Amendment. In rejecting the power of a state to make drug addiction an offense, this Court has noted:

> A law which made a criminal offense of such a disease [as mental illness, leprosy, or venereal disease] would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments. See *Francis* v. *Resweber,* 329 U.S. 459 [1947] [*Robinson* v. *California, supra,* 370 U.S. at 666.]

In the instant case Respondent might as well have been convicted of a "criminal offense." He was confined in a ward in which one third of the population were criminals. He slept in the same room with the criminal

patients, ate the same food, and was subject to the same regimen. Where no medical treatment is given to the committed mental "patients," the Court may find such a similarity between a nontreating "hospital" and a jail as to warrant the conclusion that involuntary commitment absent treatment is virtually punishment for an illness. Essentially "nothing [has been] accomplished beyond the hanging of a new sign—reading 'hospital'—over one wing of the jailhouse." *Powell* v. *Texas, supra,* 392 U.S. at 529.

C. Elements of the Right to Treatment

In its argument against the recognition of a constitutional right of involuntarily committed mental patients to receive treatment, Petitioner places heavy emphasis (Brief for the Petitioner, pp. 29-45) on the assertion that courts and juries are incapable of making the assessments necessary for the enforcement of this right. Amicus believes that sufficient, well-recognized professional standards do exist so that courts can review the adequacy of treatment without becoming hopelessly immersed in analysis of day-to-day medical judgments. Moreover, as noted by the court below, the fact that the limits of a right may be difficult to draw in particular cases is no reason for denying that the right exists at all, nor is it a reason for denying enforcement of that right in a clear-cut case of violation.

The jury below was instructed that "a person who is involuntarily civilly committed to a mental hospital does have a constitutional right to receive *such treatment as will give him a realistic opportunity to be cured or to improve his mental condition.*" Instruction 37 (emphasis added). Expert testimony from psychiatrists and psychologists was presented at trial by both

the plaintiff and the defendants on the issue of whether such treatment was in fact provided.

Amicus believes that adequate treatment in the constitutional sense should be defined along the lines outlined by the District Court in *Wyatt* v. *Stickney, supra.* The *Wyatt* court held that there are:

> three fundamental conditions for adequate and effective treatment programs in public mental institutions. These three fundamental conditions are: (1) a humane psychological and physical environment, (2) qualified staff in numbers sufficient to administer adequate treatment and (3) individualized treatment plans. [*Id.,* 334 F. Supp. at 1343.]

Following the legal ruling that these quoted standards are constitutionally required, practical experience has shown that the parties, with the aid of professional groups as amici, can agree on minimum standards as applied to a particular case. *See* detailed minimum standards set forth in *Wyatt* v. *Stickney, supra,* 344 F. Supp. at 383. *See also Wyatt* v. *Aderholt, supra,* slip op. at 716:

> Neither in the district court nor on appeal to this Court have the defendants challenged the detailed set of standards articulated by the district court. They have conceded that if there is a constitutional right to treatment enforceable by a suit for injunctive relief in federal court, those standards accurately reflect what would be required to ensure the provision of adequate treatment.

Amicus feels that there are appropriate and workable legal standards by which the constitutional right to treatment can be judicially defined, implemented and enforced. In a recent report of the American Psy-

chiatric Association's Task Force on the Right to Care and Treatment, the Task Force offered the following definition of treatment (and care, which it distinguished from treatment):

> Adequate care and adequate treatment will be defined separately. Indices of adequate care can be objectively stated with reasonable ease and precision—but the problem of developing criteria for adequate treatment is considerably more complex and more controversial. Adequate care includes the availability of medical care, nutritious and palatable food in sufficient quantity, humane shelter in an uncrowded and pleasant setting, and protection from self and others. These aspects of care should be incorporated *in a total environment which is compatible with basic human comfort and dignity.* Further, the caring environment should be only as restrictive of personal liberty as is necessary to protect and meet the needs of the patient and society. Minimal objective standards have and can be established to define these indices of care. The American Psychiatric Association has periodically developed and reviewed such standards, and has participated in the development of those which are currently in use by the Joint Commission on the Accreditation of Hospitals.[18]
>
> Assurance that adequate treatment is available in a particular hospital or other setting is best achieved by assuring the availability of *a professional staff which is adequate in numbers and training.* Treatment is defined to include active intervention of a psychological, biological, physical, chemical, educational, moral or social nature, where there is some reason to expect that the application of *an individual treatment plan is felt to have a reasonable expectation of improving the patient's condition.* [AMERICAN PSYCHIATRIC ASSOCIATION, POSITION PAPER ON THE RIGHT TO ADEQUATE CARE AND TREATMENT FOR THE MENTALLY ILL AND MENTALLY RETARDED (4th Draft, Oct. 19, 1974) (emphasis added).]

[18] Indeed, the Joint Commission has appointed an Accreditation Council for Psychiatric Facilities to accomplish these purposes.

It can be seen that the APA Task Force definition comports fully with the tripartite judicial standard in *Wyatt* v. *Stickney, supra,* and also with the jury instruction given in the case at hand. Moreover, sufficiently detailed criteria exist for courts to use in applying this broad definition to specific cases. *See, e.g.,* AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR PSYCHIATRIC FACILITIES (rev. ed. 1974). While Amicus agrees with Petitioner that there are many different approaches to psychiatry, Amicus disagrees that these differences within the profession preclude a judicial review of the presence or absence of the objectively stated criteria here proposed.

The first standard stated above in the definition of the constitutional right to treatment—a humane psychological and physical environment—is certainly the *sine quo non* of any therapeutic procedures. Such an environment must satisfy the physiological as well as the psychological needs of the patients if care and treatment are to be administered adequately. The APA's *Standards for Psychiatric Facilities* speaks specifically to such objective requirements as space, heating, ventilation, privacy in toilet and bathing areas, day rooms and recreation areas, and conference rooms. *Id.* at 64-66. There is a recognition in the psychiatric community that such facilities must "be designed to promote comfort and dignity and to ensure privacy consistent with the patients' welfare." *Id.* at 65.

Certainly, the court below was correct in holding that when a patient receives "only the kind of subsistence level custodial care he would have received in a prison," 493 F.2d at 512, the standard for adequate treatment of civilly committed patients has not been met.

As to the second factor to be taken into consideration in the judicial evaluation of adequacy of treatment—qualified staff in numbers adequate to administer treatment—there clearly are standards in this area on which agreement of experts can be obtained. For example, in 1958 the American Psychiatric Association promulgated standards for the minimum level of staffing necessary for a public mental hospital to provide even the lowest level of acceptable care. AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS 61 (rev. ed. 1958). These minimal standards have served as guideposts for the courts in right-to-treatment litigation. *See Rouse v. Cameron, supra,* 373 F.2d at 457-58 & n.33. *See also Wyatt v. Stickney, supra,* 344 F. Supp. at 383.

The final area in which it is urged the courts should set the parameters of the constitutional adequacy of treatment—an individual treatment plan—deals with what is more properly called "treatment" as opposed to "care." The two former indices look toward institution-wide criteria, the third toward the institutionalized individual. There must be a recognized plan of treatment which takes into account the situation, needs and prognosis of the individual patient. At this point it is of course necessary for discretion to play a role. Nor is such a division alien to other areas of forensic medicine. Traditionally in torts, for example, the legal adequacy of treatment is judged in

accordance with standards set by a responsible segment of the medical community:

> Where there are different schools of medical thought, it is held that the dispute cannot be settled by the law, and the doctor is entitled to be judged according to the tenets of the school he professes to follow. . . . A "school" must be a recognized one with definite principles . . . . [W. PROSSER, HANDBOOK OF THE LAW OF TORTS 166 (3d ed. 1964).]

Indeed, a similar standard has already been formulated in the context of fleshing out the meaning of a statutory right to treatment in *Rouse* v. *Cameron, supra.* The *Rouse* Court held that the legal standard of adequate treatment did not require the state to show its treatment would in fact cure or improve the patient, but only that there was a bona fide effort;[19] and further that proof that there is *better* treatment does not necessarily make inadequate the one provided.

With these standards the constitutional right to treatment can be judicially supervised without undue interference into doctors' decisions concerning proper diagnosis and therapy in each case. As the court stated in *Tribby v. Cameron,* 379 F.2d 104, 105 (D.C. Cir. 1967) (emphasis added):

> The court's function here resembles ours when we review agency action. We do not decide whether the agency has made the best decision, but only make sure that *it has made a permissible and reasonable decision in view of the relevant information and within a broad range of discretion.*

---

[19] Jury Instruction No. 37 given in this case defined adequate treatment as that which would give the patient "a realistic opportunity" to be cured or to improve his mental condition.

Thus, recognition of a constitutional right to treatment should not require "sweeping judicial surveillance over the choice of therapy. . . . Judicial consideration, therefore, would be largely limited to determining whether the choice of therapy was a conscious medical decision rather than neglect; obviously judges have no competence to evaluate the *quality* of a given choice of treatment." *Dobson v. Cameron,* 383 F.2d 519, 523-24 n.2 (D.C. Cir. 1967) (Berger, J., concurring).

While courts cannot and should not employ their resources to arbitrate between conflicting professional approaches concerning the most desirable treatment plan for a particular patient, there are sufficient professional standards recognized within the psychiatric community so that the courts can ensure that a reasonable form of treatment is provided to each individual psychiatric patient.

II. PSYCHIATRISTS EMPLOYED AT STATE INSTITUTIONS SHOULD BE IMMUNE FROM PERSONAL LIABILITY FOR DAMAGES WHEN THEY HAVE MADE A GOOD FAITH EFFORT TO COMPLY WITH CONSTITUTIONAL REQUIREMENTS FOR TREATMENT.

The courts below found the individual doctors employed by Chattahoochee personally liable for the monetary damages resulting from inadequate treatment provided at that institution. In so holding, the lower courts gave exceedingly short shrift to the arguments that the doctors were acting in good faith, that they were attempting to comply with the law as they reasonably understood it, and that the real cause of Mr. Donaldson's injury was the inadequacy of the institutional resources available for his treatment. To ignore such arguments not only results in extreme injustice to individual doctors, who must pay large sums of money for conditions over which they have no

control, but also endangers enforcement of the essential right to treatment that the courts below were seeking to advance.

The briefs of the parties will deal in detail with the question of whether the evidence in the record was sufficient to establish the doctors' good faith. Thus, Amicus will not repeat or review those arguments here. Instead, Amicus wishes to explore what it believes should be the proper standards for a showing of good faith in cases of this kind, and to emphasize the importance of such standards to the future of mental health care in this country.

In determining whether an individual psychiatrist has made a good faith effort to provide adequate treatment for his or her patients, it is essential that the courts focus clearly on the institutional setting in which that doctor is working. When treating an automobile accident victim, a surgeon working under emergency roadside conditions is not expected to meet the same standard of care as if he or she had available the advantages of a modern hospital's intensive care unit and team of supporting specialists. The range of resources available to psychiatrists in different institutional settings is just as great. Therefore, the treatment that psychiatrists provide must be viewed in this institutional context in order to judge fairly whether they have made a good faith effort to treat their patients.

A recent study revealed that the nationwide average patient-psychiatrist ratio in state-run mental hospitals is approximately 70-1.[20] County mental hos-

[20] *See* NAT'L INST. MENTAL HEALTH, STAFFING OF MENTAL HEALTH FACILITIES, UNITED STATES, 1972, at 53 (DHEW Pub. No. (ADM) 74-28, 1974).

pitals, however, still average 500 patients per psychiatrist.[21] The range of patient-psychiatrist ratios throughout the nation is so great that the average psychiatrist in a public mental hospital in Alabama, for example, is responsible for *143 times more patients* than a doctor employed by such a hospital in Colorado.[22]

During Mr. Donaldson's fourteen-year confinement at Chattahoochee, the ratio of patients per staff psychiatrist averaged approximately 800-1. *See* Record at 467. After performing other medical and administrative duties, the average hospital staff psychiatrist is able to devote only 47% of his or her time to direct patient care.[23] Thus, if each doctor spent an equal amount of time with each patient, as little as one or two minutes per week would have been available for psychiatric "treatment" of each patient at Chattahoochee. Meaningful psychiatric care was not, and cannot be, provided under such circumstances.

The American Psychiatric Association has promulgated standards for the minimum level of staffing necessary for a public mental hospital to provide even the lowest level of acceptable care.[24] These are truly minimum standards, since they "represent a compromise between what was thought to be adequate and

[21] *Id.*

[22] *Compare* NAT'L INST. MENTAL HEALTH, STATISTICAL NOTE 109, STAFFING OF STATE AND COUNTY MENTAL HOSPITALS, UNITED STATES, 1973, at Table 1 (Aug., 1974) (Alabama), *with id.* at Table 1 (Colorado).

[23] JOINT INFORMATION SERVICE, AMERICAN PSYCHIATRIC ASS'N & NAT'L ASS'N FOR MENTAL HEALTH, ELEVEN INDICES 14 (1971).

[24] AMERICAN PSYCHIATRIC ASSOCIATION, STANDARDS FOR HOSPITALS AND CLINICS 61 (rev. ed. 1958).

what it was thought had some possibility of being realized." Solomon, *The American Psychiatric Association in Relation to American Psychiatry,* 115 AM. J. PSYCHIAT. 1, 7 (1958). Yet even these minimal standards, which have been accepted as guideposts by the courts,[25] demonstrate that Chattahoochee needed a vastly larger number of doctors than it actually had in order to provide adequate treatment to its resident population. The A.P.A. standards allow no more than thirty acutely ill patients, or 150 chronically ill patients, per full-time psychiatrist. Thus, while each psychiatrist at Chattahoochee averaged 800 patients, of whom approximately 350 were acutely ill,[26] minimum staffing standards demanded *fifteen* full-time psychiatrists in order to provide adequate treatment to those same patients.

The Court of Appeals analysis of the doctors' liability completely ignores this evidence of the hopelessly inadequate staffing and resources at Chattahoochee. Amicus submits that a legal standard of good faith which allows a jury to find doctors personally liable without consideration of such evidence[27] is really no standard at all.

[25] *See Rouse* v. *Cameron, supra,* 373 F.2d at 457–58 & n.33. *See also Wyatt* v. *Stickney, supra,* 344 F. Supp. at 383.

[26] *See* Brief for the Petitioner, at 7.

[27] As will be discussed in more detail below, the trial court should have instructed the jury to take into account any evidence of limited staff and resources available at Chattahoochee when the jury considered Dr. O'Connor's defense that he made a good faith effort to comply with his legal duty, as he understood it. The lower courts also should have reviewed the propriety of the jury verdict in light of this standard.

It is not clear whether Petitioner properly raised this issue before the trial court. The parties' briefs undoubtedly will discuss

This Court has emphasized repeatedly that state officials should not be liable personally for damages when they have acted in good faith in the performance of their duties. In *Pierson v. Ray,* 386 U.S. 547 (1967), the Court held that plaintiffs could not recover damages from individual police officers for an unconstitutional arrest "if the jury found that the officers reasonably believed in good faith that the arrest was constitutional." *Id.* at 557. The Court last Term in *Scheuer v. Rhodes,* 416 U.S. 232 (1974), made clear that this "qualified immunity" not only extends to more senior state officials, but in fact should be broader as the defendant's "scope of discretion and responsibilities" is broader. *Id.* at 247. *See also Doe v. McMillan,* 412 U.S. 306, 320 (1973).

The official immunity doctrine "seeks to reconcile two important considerations—

> '[O]n the one hand, the protection of the individual citizen against pecuniary damage caused by oppressive or malicious action on the part of [government officials]; and on the other, the protection of the public interest by shielding responsible governmental officers against the harassment and inevitable hazards of vindictive or ill-founded damage suits brought on account of action taken in the exercise of their official responsibilities.'" [*Doe v. McMillan, supra,* 412 U.S. at 319, *quoting Barr v. Matteo,* 360 U.S. 564, 565 (1959).]

that point, and the related question whether the lower courts' failure to consider this issue amounted to "plain error," reviewable in the absence of any objection by the parties. *See, e.g., Silber v. United States,* 370 U.S. 717, 718 (1962); *United States v. Atkinson,* 297 U.S. 157, 160 (1936). Whatever the Court's resolution of these questions, Amicus believes that it is essential that the Court's opinion here emphasize the proper contours of the good faith defense for the guidance of potential litigants and the lower courts.

One court has summarized the doctrine as allowing "a qualified immunity based on good faith performance of duty as the officials understood it." *Roberts v. Williams,* 456 F.2d 819, 831 (5th Cir.), *cert. denied,* 404 U.S. 866 (1971); *accord, e.g., Gaffney v. Silk,* 488 F.2d 1248, 1250 (1st Cir. 1973). Thus, the defense consists of two basic elements. First, courts must focus on the official's understanding of his or her duty; the courts will consider the defense in light of that understanding, so long as it is reasonable, even if incorrect. The second element [28] of the defense provides immunity when the official made a good faith effort to meet that duty, as so understood, even if the effort was unsuccessful.

Regarding the first part of the defense, the law is well settled that a state official should not be held personally liable for a civil rights violation when he or she had tried in good faith to follow then-existing constitutional principles, even if those principles later were overturned. As this Court held in *Pierson v. Ray, supra,* 386 U.S. at 557, state officers are not "charged with predicting the future course of constitutional law." They "neither can nor should be expected to be seers in the crystal ball of constitutional doctrine." *Westberry v. Fisher,* 309 F. Supp. 12, 17 (D. Me. 1970).

[28] In a case where the definition of defendant's legal duty is clear, only the latter element of the defense is relevant. In the instant case, however, where the constitutional contours of the duty are still developing, the two elements are interrelated. Thus, defendant's good faith effort must be measured against whatever legal duty he reasonably should have known was applicable. The question of whether an objective or subjective standard is appropriate in assessing whether a defendant made such a "good faith effort" is now pending before the Court in *Wood* v. *Strickland, cert. granted,* 94 S. Ct. 1932 (No. 73-1285, Apr. 15, 1974).

In the instant case, a constitutional right to treatment was little more than a gleam in the eye of its most ardent proponent during Mr. Donaldson's confinement, which began in 1957. The article generally credited as the first even to suggest such a right appeared in 1960. Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499 (1960); *see* 493 F.2d at 519-20 & nn.12, 14. Several courts during the 1960's refused to recognize the existence of a constitutional right to treatment. *See, e.g., People ex rel. Anonymous v. La Burt,* 14 App. Div. 2d 560, 218 N.Y.S.2d 738 (1961), *appeal dismissed and cert. denied,* 369 U.S. 428 (1962). Indeed, Mr. Donaldson himself brought several earlier right-to-treatment claims against Dr. O'Connor, and the courts consistently rejected these claims. *See, e.g., Donaldson v. O'Connor,* 234 So. 2d 114 (Fla. 1969), *cert. denied,* 400 U.S. 869 (1970). *See also Donaldson v. O'Connor,* 390 U.S. 971 (1968); *Donaldson v. Florida,* 371 U.S. 806 (1962); *In re Donaldson,* 364 U.S. 808 (1960). It was not until 1971, the year of Mr. Donaldson's release from Chattahoochee, that the first court held that there should be a constitutional right to treatment. *Wyatt v. Stickney, supra,* 325 F.Supp. 781.

Not only is the constitutional right to treatment a very recent development, but the past decade has also seen major changes in the professional approach toward psychiatric treatment of the seriously mentally ill. Beginning in the 1960's psychiatrists began to recognize that long-term custodial care of the mentally ill, in large and dehumanizing institutions situated in isolated settings, was often counterproductive and therefore should be resisted. Many patients—even those with the most serious mental illness (such as that diagnosed in Mr. Donaldson's case)—could be rapidly returned to home and community. This approach was made possible in part by the advent of effective medications which moderated the symptoms and allowed patients to be managed in the community.

With or without such medications the fundamental approach to most of these patients has now been modified, and every attempt is made to return them to home, family, work, and community as soon as possible. This strategy, the "community mental health approach," has revolutionized the treatment of the mentally ill. That revolution, however, is incompletely realized; many communities lack the facilities, personnel, and outreach programs which make it possible.

Mr. Donaldson was originally hospitalized at a time when the community mental health approach had not been clearly formulated or generally accepted. Much of the testimony given in his case assumes the general acceptance of the community mental health approach without recognizing the changes which were occurring in psychiatry during that period. Thus, not only was Dr. O'Connor judged by a new legal standard, but also his approach to treatment was measured in terms of a new psychiatric perspective.

Under these circumstances it is unfair and contrary to the principle this Court stated in *Pierson v. Ray* to apply the right-to-treatment principle retroactively by holding psychiatrists personally liable for damages dating back many years before they could have known of this new constitutional duty.[29] Other Circuits have recognized the necessity of "providing conscientious state officials with some protection against the cutting edge of a rapidly developing legal

[29] The courts below did not address this retroactivity issue. *See* note 27, *supra.*

doctrine." *Eslinger v. Thomas,* 476 F.2d 225, 229 (4th Cir. 1973). In *Eslinger,* plaintiff challenged the policy of the clerk of the South Carolina State Senate that women were ineligible to serve as senate pages. The Fourth Circuit held that injunctive relief was proper, since the discriminatory policy ran afoul of current constitutional requirements of equal protection. The court went on, however, to reverse the lower court's ruling that the clerk should be liable for damages. The court noted that the defendant's actions had taken place at a time when the law generally tolerated sex-based classifications. *Id.* at 230 & n.5. "Although the clerk may have acted with little sensitivity . . . he acted in the light of a long-standing, albeit vaguely defined, 'custom' . . . . He did no more, or less, than what had always been done." *Id.* at 229. The Fourth Circuit concluded that the defendant should not be liable for failing to foresee a new constitutional principle. *Id.*; *accord, e.g., Haines v. Kerner,* 492 F.2d 937, 941 (7th Cir. 1974) (conduct of officials "should be tested against constitutional doctrine as described in prevailing judicial decisions at the time of their action"); *Skinner v. Spellman,* 480 F.2d 539 (4th Cir. 1973) (no damages against official acting in "reasonable good faith reliance on what was standard operating procedure"); *Clarke v. Cady,* 358 F. Supp. 1156, 1163 (W.D. Wisc. 1973) (prison warden "immune from damages under § 1983 when he reasonably relies upon the validity of a prison practice which has only subsequently been determined to be unconstitutional"). Thus, as the court stated in *Collins v. Schoonfield,* 363 F. Supp. 1152, 1156 (D. Md. 1973), "it would contravene basic notions of fundamental fairness if [state] officials were held to be liable monetarily for acts which

they could not reasonably have known were unlawful."[30]

The second element of the good faith defense that should be available in cases such as this would forbid personal liability whenever the doctor makes a good faith, even if unsuccessful, effort to meet the duty he or she reasonably understands is owed to the patient. Numerous courts have applied this qualified immunity principle to a wide variety of official positions. *See, e.g., Strickland v. Inlow,* 485 F.2d 186, 191 (8th Cir. 1973), *cert. granted sub nom. Wood v. Strickland,* 94 S. Ct. 1932 (No. 73-1285, Apr. 15, 1974) (school board members); *Handverger v. Harvill,* 479 F.2d 513, 516 (9th Cir.), *cert. denied,* 414 U.S. 1072 (1973) (university officials); *Jones v. Perrigan,* 459 F.2d 81, 83 (6th Cir. 1972) (FBI agent); *Harrison v. Brooks,* 446 F.2d 404, 407 (1st Cir. 1971) (town officials); *Mitchell v. Boslow,* 357 F. Supp. 199, 202-03 (D. Md. 1973) (director of state institution for "defective delinquents"). The principle is at least equally applicable to staff psychiatrists and hospital officials, whose "scope of discretion and responsibilities" is necessarily broad,

---

[30] Equitable relief, of course, should always be available to insure compliance with newly developing legal standards. *See Jannetta v. Cole,* 493 F.2d 1334, 1338 (4th Cir. 1974):

> . . . while there is nothing in §1983 or the fourteenth amendment to suggest that an improper motive is requisite for a federal cause of action, conscientious state officials, when acting reasonably and in good faith, should not be expected to answer in money damages for failure to accurately predict the future course of constitutional doctrine, even though such failure may entitle a plaintiff to equitable relief.

See also Briscoe v. Kusper, 435 F.2d 1046, 1057-58 (7th Cir. 1970). Thus, the good faith defense in no way defines the right; it simply limits the remedy to equitable relief and to damages against the institution or officials who have not acted in good faith.

since they must make countless on-the-spot expert judgments each day in treating their patients. *See Doe v. McMillan, supra,* 412 U.S. at 320; *Smith v. Losee,* 485 F.2d 334, 342 (10th Cir. 1973) (en banc).

This good faith defense is particularly appropriate where, as here, fulfillment of defendant's duty is seriously hampered by thoroughly inadequate resources.[31] All that can reasonably be asked in these circumstances is that the official make a good faith effort with the limited resources available. For example, in *Schmidt v. Wingo,* 499 F.2d 70 (6th Cir. 1974), *affirming* 368 F. Supp. 727 (W.D. Ky. 1973), plaintiff sought damages from the defendant prison warden, alleging that plaintiff's decedent, a prison inmate, died as a result of inadequate medical care furnished at the prison hospital. The court in *Schmidt* recognized that it would be both illogical and unjust "to place liability upon the Warden of a penitentiary for the failure to furnish [adequate] equipment and personnel, where the budget for personnel and equipment are fixed by his superiors, the Department of Corrections and by the General Assembly of the State of Kentucky." 368 F. Supp. at 731; *see* 499 F.2d at 74.

Similarly, in the instant case the state legislature failed to appropriate sufficient funds to reduce the institution's patient-psychiatrist ratio to a level that would allow for meaningful treatment. Under such circumstances, it is far too easy for jury members—justifiably sympathetic to the plight of the plaintiff who has been confined without treatment for many years—to award damages against whatever defendant

[31] Indeed, in such cases the "good faith defense" may merge with the question whether plaintiffs can show that defendant's actions were the proximate cause of the alleged injuries.

happens to be before them.[32] Where the gravamen of the complaint is failure to provide enough treatment—as opposed to allegations of affirmative acts of malicious mistreatment [33]—proper application of this "good faith" standard should result in a verdict for defendant physicians as a matter of law whenever the evidence shows that the failure to treat resulted from inadequate resources, rather than from any personal animus.

Amicus has discussed at pp. 18-24, above, what it believes should be the basic elements of the constitutional right to treatment—the institution should provide a humane environment, adequate staff, and an individual treatment plan for each patient. Proper application of the good faith defense to these cases should immunize doctors from personal liability whenever they are using their best efforts to comply with these basic standards. It is important to emphasize that this case should not elevate to constitutional dimensions the myriad of day-to-day medical decisions that must be made in treating each patient. Indeed, it could paralyze these institutions if every doctor were

[32] *See generally Gregoire v. Biddle,* 177 F.2d 579, 581 (2d Cir. 1949):

> Again and again the public interest calls for action which may turn out to be founded on a mistake, in the face of which an official may later find himself hard put to it to satisfy a jury of his good faith. There must indeed be means of punishing public officers who have been truant to their duties; but that is quite another matter from exposing such as have been honestly mistaken to suit by anyone who has suffered from their errors.

[33] Amicus will defer to the parties' briefs on the question of whether the record here reflects a claim of bad faith mistreatment of, or simply insufficient attention to, Mr. Donaldson.

subject to a civil rights damage action in federal court each time he or she prescribed a drug, decided on a change in therapy, or acted on a request for furlough or work assignment. The Constitution does not prohibit exercise of the doctor's good faith professional judgment on any of these matters. What the Constitution should require from each doctor is a good faith effort to use the resources provided by the institution, along with the doctor's professional skill, in order to provide involuntarily committed patients the treatment implicitly promised by the state when it deprives them of their liberty.

It is an unspeakable tragedy when a mentally ill person is crowded into a facility like Chattahoochee, given little or no medical treatment, and allowed to remain there for years on end. Amicus believes strongly that such conditions violate the patient's constitutional right to treatment. The primary responsibility for a remedy, however, must lie with those who have the power to correct these conditions.[34]

The courts can find effective remedies for these problems by focusing on the institutional setting and resources available for treatment. In *Wyatt v. Aderholt, supra,* the court has used its equitable power by requiring state institutions to increase their staff-patient ratio and to make other systemic changes nec-

[34] Supporters of the right to treatment generally recognize that the understaffing and lack of physical facilities that plague our state mental institutions are not the fault of the psychiatrists or others who work there. "Our society should be grateful to, rather than adversely critical of, the personnel who continue to work in these institutions under the present trying conditions." Birnbaum, *The Right to Treatment,* 46 A.B.A.J. 499, 500 (1960); *accord, e.g.,* Birnbaum, *Some Remarks on "The Right to Treatment,"* 23 ALA. L. REV. 623, 628 (1971).

essary to provide adequate care. *See id.,* slip op. at 724. The American Psychiatric Association participated in the *Wyatt* case, supporting the right to treatment and urging the court to order a variety of needed institutional reforms. *See* Motion of American Psychiatric Association for Leave to Participate as Amicus Curiae, *Wyatt v. Aderholt,* No. 72-2634 (5th Cir., filed Dec. 4, 1972). The other right-to-treatment cases relied upon by the court below similarly focus on institutional reforms and injunctive relief. *See Welsch v. Likins, supra; Stachulak v. Coughlin,* 364 F. Supp. 686 (N.D. Ill. 1973). *See also Rouse v. Cameron, supra,* 373 F.2d at 458-59 (institutions must release patient receiving inadequate treatment). When a state institution fails to meet these minimum standards identified by the courts, patients should have a cause of action *against the responsible state agency.*[35] *See Whitree v. State,* 56 Misc. 2d 693, 290 N.Y.S.2d 486 (Ct. Cl. 1968) ($300,000 award against state for improper custodial confinement of mental patient). Indeed, such actions may be a most effective method to loosen the legislatures' pursestrings, so that sufficient resources do become available. *See* 82 HARV. L. REV. 1771, 1776-77 (1969).

Instead of such institutional remedies, the Fifth Circuit has held in this case that the doctor who works on the staff of an overcrowded hospital can be personally liable for damages to patients who receive inadequate treatment. This decision has frightening implications for the very patients whose right to treatment the court was seeking to protect. Unless this

[35] The doctor should be personally liable, of course, if he or she fails to make a good faith effort to meet such clearly identified minimum standards, or if the doctor commits any acts of malpractice. *See generally* Morse, *Tort Liability of the Psychiatrist,* 18 SYR. L. REV. 691 (1967).

Court clearly emphasizes the availability of a good faith defense in cases such as this, it would be foolish for qualified doctors to continue working at Chattahoochee or the many other institutions that are similarly understaffed. Rather than stay in a system where their best efforts could not eliminate constant exposure to large damage awards, doctors will seek positions at the better-staffed institutions, or possibly even depart from institutional employment. Rather than increasing the quality and quantity of treatment available at Chattahoochee, the decision below will lead to just the opposite result, substantially undermining the very right to treatment it seeks to establish.

Amicus is also extremely concerned that the decision below might force institutions to release prematurely thousands of mental patients who are very much in need of care and treatment. There no doubt are many patients now in state institutions for whom release would be perfectly appropriate. Nevertheless, without further clarification by this Court of the standards for enforcement of the right to treatment, the threat of damage actions such as this one may well lead to far more widespread deinstitutionalization than is medically indicated.

Mr. Donaldson claims that, even if the resources at Chattahoochee *were* insufficient, Dr. O'Connor should be liable in damages for failing to release Mr. Donaldson once the doctor knew that adequate treatment was not being provided. But it is far too easy and misleading to characterize a doctor's decision in each case as simply whether to treat or release a patient. In the vast majority of the nation's mental institutions, doctors are providing *some* beneficial treatment to all their patients, even though the amount of treatment may be much less than the optimum in many cases. The

Court must be careful that its formulation of the right to treatment, and particularly the remedial standards for that right, do not prompt a massive reduction of the number of patients that the state will assist. A rule that forces psychiatrists prematurely to declare ready for release into society a large percentage of their mentally ill patients—so that the remaining few will receive better treatment—would be less equitable than the present mental health care system. Moreover, it might encourage the release of some patients who are extremely difficult to treat effectively, but who may be dangerous to society. *See* American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 AM. J. PSYCHIAT. 1458, 1459-60 (1967) (emphasis added):

> On the basis of long experience, psychiatrists estimate that about 90 percent of all mental hospital patients are harmless and in no way threaten the community in which they reside. However, the other 10 percent comprise roughly 60,000 patients; protecting the community from irresponsible acts they might commit is a priority social concern. *To release them prematurely is never justified regardless of the adequacy of treatment they may be receiving. The constructive way of approaching this problem lies in obtaining the staff and facilities for providing adequate treatment, not in premature release.*

Many patients now confined could be treated adequately in alternative outreach, or community, facilities. Where such facilities are not available, however, the choice that a doctor faces is between providing some treatment or no treatment at all. Amicus does not suggest that large state hospital institutions are the best way to treat many of the patients now confined in such

institutions. Rather, Amicus does wish to emphasize that without the availability of alternative facilities, such patients would simply be abandoned.

Doctors trying in good faith to provide the best treatment possible with the available resources should not have to choose between risking personal liability for damages, or violating their professional standards by refusing to treat people in need of medical help.

The Court of Appeals indicated in its opinion that the "core of the charge" against Dr. O'Connor was that he confined Mr. Donaldson "knowing that the patient was not receiving adequate treatment and knowing that absent such treatment the period of his hospitalization would be prolonged." 493 F.2d at 513. The tragic truth is that the inadequate resources in our state mental hospitals today require many of our country's best psychiatrists in painful candor to confess their guilt to this same charge. The question this Court should address here is whether our judicial system can help correct the institutional inadequacies that are depriving thousands of mental patients of their fundamental rights, or whether instead the judicial response will be to punish and drive away the people who are doing the most to deal with these problems.

CONCLUSION

For the foregoing reasons, Amicus respectfully urges this Court to affirm the holding of the court below that involuntarily committed mental patients have a constitutional right to treatment, while clarifying the standards which lower courts should apply to damage actions for violation of that right.

Respectfully submitted,

E. Barrett Prettyman, Jr.
Allen R. Snyder
Gail Starling Marshall
Hogan & Hartson
815 Connecticut Avenue
Washington, D.C. 20006
Attorneys for Amicus Curiae
American Psychiatric Association

Supreme Court, U. S.
FILED
JAN 7 1975
MICHAEL RODAK, JR., CLERK

In The

Supreme Court of the United States

October Term, 1974

No. 74-8

J. B. O'CONNOR, M.D. and JOHN GUMANIS, M.D.,

Petitioners,

vs.

KENNETH DONALDSON,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit.

BRIEF *AMICUS CURIAE* ON BEHALF OF THE COMMITTEE ON MENTAL HYGIENE OF THE NEW YORK STATE BAR ASSOCIATION

SIMON ROSENZWEIG, Chairman
27 Madison Avenue
New York, New York 10010

JUNE RESNICK GERMAN
23 West 76th Street
New York, New York 10023

RONALD N. GOTTLIEB
27 Madison Avenue
New York, New York 10010

ALFRED BERMAN
80 Pine Street
New York, New York 10005

Members of the Sub-Committee on the Brief for the Amicus Curiae *Committee on Mental Hygiene of the New York State Bar Association*
One Elk Street
Albany, New York 12207

TABLE OF CONTENTS

Page

Interests of the Amicus Curiae 2

Summary of Argument 4

Argument:

Involuntary civil patients have a constitutional right to treatment grounded in the Due Process Clause of the Fourteenth Amendment. Such right includes the right not to be deprived of liberty without due process of law and the proscription against cruel and unusual punishment. . 4

Conclusion 14

TABLE OF CITATIONS

Cases Cited:

Aptheker v. Secretary of State, 378 U.S. 500 (1964) 5

Baxstrom v. Herold, 383 U.S. 107 (1966) 8

Board of Regents v. Roth, 408 U.S. 564 (1972) 6

Donaldson v. O'Connor, 493 F.2d 507 (1974) 2

Eisenstadt v. Baird, 405 U.S. 438 (1972) 6

Contents

Page

Fhagen v. Miller, 29 N.Y. 2d 348, cert. denied, 409 U.S. 845 (1972) 5

Griswold v. Connecticut, 381 U.S. 479 (1965) 6

Humphrey v. Cady, 405 U.S. 504 (1972) 10

Inmates of Boys Training School v. Affleck, 346 F. Supp. 1354 (D.R.I. 1972) 12

Inmates of Suffolk County Jail v. Eisenstadt, 360 F. Supp. 676 (D. Mass. 1973), aff'd., 494 F.2d 1196 (1st Cir. 1974) ... 5

Jackson v. Indiana, 406 U.S. 715 (1972) 10, 12

Kesselbrenner v. Anonymous, 33 N.Y. 2d 161, 350 N.Y.S. 2d 889 (1973) 3, 5, 12

Martarella v. Kelley, 349 F. Supp. 575 (S.D.N.Y. 1972) 3, 12

Morales v. Turman, 364 F. Supp. 166 (E.D. Tex. 1973) 12

Nason v. Superintendent, 233 N.E. 2d 908 (Mass. 1968) 12

Nelson v. Heyne, 491 F.2d 352 (7th Cir. 1974), cert. denied, 417 U.S. 976 (1974) 12

New York State Association for Retarded Children v. Rockefeller, 357 F. Supp. 759 (E.D.N.Y. 1973) 3

Contents

Page

O'Connor v. Donaldson, 43 U.S.L.W. 3239 (October 22, 1974) 2

People v. Fuller, 24 N.Y.2d 292, 300 N.Y.S.2d 102 (1969) .. 9, 12

Powell v. Texas, 392 U.S. 514 (1968) 8, 10

Robinson v. California, 370 U.S. 660 (1962) 6, 8, 9, 10

Roe v. Wade, 410 U.S. 113 (1973) 5, 6

Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966) 12

Schuster v. Herold, 410 F.2d 1071 (2d Cir.), cert. denied, 396 U.S. 847 (1969) 3

Shapiro v. Thompson, 394 U.S. 681 (1968) 5

Shelton v. Tucker, 364 U.S. 479 (1960) 4

Sherbert v. Verner, 374 U.S. 398 (1962) 4

Stachulak v. Coughlin, 364 F. Supp. 686 (N.D. Ill. 1973) 12

Welsch v. Likens, 373 F. Supp. 487 (D.Minn. 1974) 12

Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) 12

Contents

Page

Wyatt v. Stickney, 325 F. Supp. 781 (M.D. Ala. 1971), hearing ordered, 334 F. Supp. 1341 (M.D. Ala. 1971), enforced, 344 F. Supp. 373 (M.D. Ala. 1972) 12

Statutes Cited:

New York Correction Law §375 8

New York Mental Hygiene Law §2 8

New York Narcotic Control Act of 1966 9

United States Constitution Cited:

Eighth Amendment 7

Fourteenth Amendment 4, 6, 7, 13

Other Authorities Cited:

Birnbaum, The Right to Treatment, 46 A.B.A.J. 499 (1960) . 12

Note, Civil Restraint, Mental Illness, and the Right to Treatment, 77 Yale L.J. 87 (1967) 13

Note, Developments in the Law—Civil Commitment of the Mentally Ill, 87 Harvard Law Rev. 1190 (1974) 12

Contents

Page

Note, Due Process for All—Constitutional Standards for Involuntary Civil Commitment and Release, 34 Univ. Chi. Law Rev. 633 (1967) 13

Note, the Nascent Right to Treatment, 53 Univ. Va. Law Rev. 1134 (1967) 13

Symposium, The Mentally Ill and the Right to Treatment, 36 Univ. Chi. Law Rev. 742 (1969) 12

Symposium, The Right to Treatment, 57 Georgetown 673 (1969) 12

In The

Supreme Court of the United States

October Term, 1974

No. 74-8

J. B. O'CONNOR, M.D. and JOHN GUMANIS, M.D.,

Petitioners,

vs.

KENNETH DONALDSON,

Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit.

BRIEF *AMICUS CURIAE* ON BEHALF OF THE COMMITTEE ON MENTAL HYGIENE OF THE NEW YORK STATE BAR ASSOCIATION

This brief *amicus curiae* addresses itself to the merits of the question presented. The Committee on Mental Hygiene of the New York State Bar Association files this brief pursuant to Rule 42 of the United States Supreme Court. Both petitioners and respondent have consented to the filing of this brief and copies of the consents of petitioners and respondent have been filed with the Clerk of this Court.

INTERESTS OF THE *AMICUS CURIAE*

The New York State Bar Association (the "Association") is a voluntary association incorporated by an act of the legislature of May 2, 1877 and has a present membership of 23,904 members.

It has sixty-five Standing Committees concerned with many areas of the law. Among them is a Committee on Mental Hygiene (the "Committee") whose charge it is that it:

> "shall study all social remedial legislation having to do with mental hygiene and recommend through the proper committees of the Association changes or additions in mental hygiene law when the same would be necessary, and in general consider any and all matters pertaining to mental hygiene and aftercare of mental hygiene patients, so far as this may be affected by the law or legislation."

The Committee has examined the issue presented on this Writ of Certiorari[1] and has requested and approved the preparation of this brief *amicus curiae*. The Association's Executive Committee has approved this brief on behalf of the Association.

The Committee is concerned about the constitutional right of institutionalized mentally disabled persons to treatment, the

1. *O'Connor v. Donaldson*, 43 U.S.L.W. 3239 (October 22, 1974), granting certiorari on *Donaldson v. O'Connor*, 493 F.2d 507 (1974).

issue which is before the court herein, because of a conflict between the state and federal courts within New York which have ruled on this issue.

The New York Court of Appeals has recently recognized a constitutional right to treatment, *Kesselbrenner v. Anonymous*, 33 N.Y. 2d 161, 350 N.Y.S. 2d 889 (1973), whereas the federal court decisions on this issue are in conflict. In *New York State Association for Retarded Children v. Rockefeller*, 357 F. Supp. 759 (E.D.N.Y. 1973) the court rejected the proposition that the right to treatment is guaranteed under the Constitution. Other courts in this Circuit have indicated that in this area and in similar areas a constitutional right to treatment would be recognized. *Schuster v. Herold*, 410 F.2d 1071 (2d Cir.), *cert. denied*, 396 U.S. 847 (1969); *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972). In view of this conflict the Association wishes to be heard in this matter and welcomes a resolution of this issue.

This case presents the first direct opportunity for the Court to decide whether an involuntarily institutionalized patient has a constitutional right to treatment. The fundamental importance of this issue requires as full a briefing as is possible. The Committee, therefore, offers its analysis to assist the Court in reaching its decision.

SUMMARY OF ARGUMENT

Mentally ill persons who are civilly confined have a constitutional right to receive treatment for their mental illness.[2] This right is grounded in the due process clause of the Fourteenth Amendment and has been recognized by this Court, by several courts of lesser jurisdiction, and by legal scholars and commentators.

ARGUMENT

INVOLUNTARY CIVIL PATIENTS HAVE A CONSTITUTIONAL RIGHT TO TREATMENT GROUNDED IN THE DUE PROCESS CLAUSE OF THE FOURTEENTH AMENDMENT. SUCH RIGHT INCLUDES THE RIGHT NOT TO BE DEPRIVED OF LIBERTY WITHOUT DUE PROCESS OF LAW AND THE PROSCRIPTION AGAINST CRUEL AND UNUSUAL PUNISHMENT.

It is the right of every person to be free of unnecessary governmental restraints. Such right may only be infringed to serve a legitimate governmental purpose conditioned, however, by the safeguards complying with the wide range of protections comprehended under the rubric of "due process of law." *Shelton v. Tucker*, 364 U.S. 479 (1960); *Sherbert v. Verner*, 374 U.S. 398

2. The Committee restricts its present analysis to the right of mentally ill persons to treatment when they are involuntarily confined, the issue on appeal herein. At the present time the Committee is taking no position with respect to the right to treatment of persons institutionalized for other mental disabilities which may involve additional considerations not treated herein.

(1962); *Aptheker v. Secretary of State*, 378 U.S. 500 (1964); *Shapiro v. Thompson*, 394 U.S. 618 (1968); *Inmates of Suffolk County Jail v. Eisenstadt*, 360 F. Supp. 676 (D. Mass. 1973), *aff'd.*, 497 F.2d 1196 (1st Cir. 1974); *Kesselbrenner v. Anonymous*, 33 N.Y. 2d 161, 350 N.Y.S. 2d 889 (1973).

Generally, deprivations of liberty are permitted for periods of limited duration if the government can establish that a crime has been committed. In such cases, accused defendants are afforded a high degree of procedural and substantive protection.

In certain other instances, persons who are not involved in the criminal justice system may also be deprived of their liberty. The mentally ill have been included as part of this group. *Fhagen v. Miller*, 29 N.Y. 2d 348, *cert. denied*, 409 U.S. 845 (1972) What constitutes due process of law for those deprived of liberty because of mental illness, and, indeed, for all the institutionalized mentally disabled, is of central importance to the scheme of mental health laws throughout the nation and to the fundamental right to liberty of all.

It is the position of the Committee that denial of liberty to a mentally ill person who is not involved in the criminal justice system can satisfy constitutional due process requirements only if such denial is based on a corresponding obligation to provide treatment and treatment is actually provided.[3]

It is manifest that, under the broadened concept of "liberty" embraced by this Court in its decisions culminating in *Roe v.*

3. The hospital should be obligated to make a good-faith showing that it has exhausted known types of treatment suitable to the illness in question and that no further therapy is available.

Wade, 410 U.S. 113 (1973). Respondent in this action clearly has a right to treatment cognizable under the Fourteenth Amendment.

As stated by Justice Stewart, in his concurring opinion, *supra*, 410 U.S. at 167 *et seq.*, the right to treatment falls within the ambit of those cases decided under the doctrine of substantive due process. [*Griswold v. Connecticut*, 381 U.S. 479 (1965); *Eisenstadt v. Baird*, 405 U.S. 438 (1972)]:

> "'In a Constitution for a free people, there can be no doubt that the meaning of "liberty" must be broad indeed.' *Board of Regents v. Roth*, 408 U.S. 564, 572. The Constitution nowhere mentions a specific right of personal choice in matters of marriage and family life, but the 'liberty' protected by the Due Process Clause of the Fourteenth Amendment covers more than those freedoms explicitly named in the Bill of Rights." 410 U.S. at 168.

This Court first gave expression to the constitutional requirement of providing treatment to persons deprived of liberty due to their mental illness in *Robinson v. California*, 370 U.S. 660 (1962). Although dealing with a California statute which provided for imposition of criminal penalties for the mere status, without more, of addiction to narcotics, this Court made a basic assumption that persons who are mentally ill could not be punished for their illness:

> "It is unlikely that any State at this moment in history would attempt to make it a criminal offense for a person to be mentally ill . . . in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments." 370 U.S. at 666.

This Court further outlined the permissible course a state or state officials might follow with regard to mentally ill persons:

> "A State might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment . . . ." 370 U.S. at 666.

Thus involuntary civil commitment may be tolerated, but only if accompanied by treatment. This principle was grounded in fundamental due process, more specifically, the Eighth Amendment proscription against cruel and unusual punishment made applicable to the states by the due process clause of the Fourteenth Amendment.

In Justice Douglas' opinion, concurring, he stated:

> "If addicts can be punished for their addiction, then the insane can also be punished for their insanity. Each has a disease and each must be treated as a sick person." 370 U.S. at 674.

In *Baxstrom v. Herold*, 383 U.S. 107 (1966), this Court had occasion to analyze procedures in New York whereby patients in Dannemora State Hospital, a correctional mental institution, who were nearing the end of a prison sentence, could be civilly retained without the procedural safeguards available to persons otherwise civilly committed. An equally important issue was in which institution the patient could be placed. This Court found that equal protection of the laws required that such mentally ill person receive the same procedural safeguards in a civil commitment proceeding available to all others.

With regard to the place of hospitalization, this Court took occasion to note "striking dissimilarities" between civil institutions operated by the Department of Mental Hygiene and Dannemora. One of the most critical dissimilarities was that Department of Correction facilities were used for the purpose of confining and caring for mentally ill persons whereas Mental Hygiene facilities were to provide care and *treatment* for mental illness. Compare former New York Correction Law §375 with former New York Mental Hygiene Law §2.

This Court subsequently analyzed the nature of civil commitment and treatment in *Powell v. Texas*, 392 U.S. 514 (1968). That case involved whether a state might constitutionally impose a criminal penalty for public intoxication. Although argument was made that alcoholism was a disease akin to drug addiction requiring treatment not punishment, as in *Robinson v. California, supra*, a divided Court rejected this contention.

Underlying the majority opinion was a concern that there was no evidence that treatment would be available to alcoholics

were they to be civilly committed. This Court reasoned that in the absence of any assured course of treatment, the more humane approach would be a short prison term which at least would give alcoholics an opportunity to become sober before being returned to the streets.

The premise of the decision was that if civil commitment were to be used for alcoholics, treatment reasonably expected to lead to freedom from "hospitalization" would have to be provided. Such treatment would have to be more than merely custodial or punitive; it would have to be reasonably effective toward assuring a prospect of eventual freedom. Since this Court found no such treatment available for alcoholics, it refused to order their civil commitment.

The New York Court of Appeals recognized the imperative of *Robinson, supra*, when, in passing upon the New York Narcotic Control Act of 1966, it declared in *People v. Fuller*, 24 N.Y. 2d 292, 300 N.Y.S. 2d 102 (1969):

> "By its terms New York's Narcotic Control Act of 1966 recognizes that drug addiction is a 'disease' and that an addict is a sick person in need of treatment . . . . The basic premise of the narcotic control program is and constitutionally must be a rehabilitative one." 24 N.Y. 2d at 301.

The Court further stated, 24 N.Y. 2d at 302-303:

> "All jails in some measure seek to have a program of rehabilitation, but in upholding, by

> way of dictum, a compulsory civil commitment program for narcotics rehabilitation, in *Robinson v. California* . . . the Supreme Court was referring to a full and complete program of treatment. Compulsory commitment must indeed be something 'beyond the hanging of a new sign — reading "hospital" — over one wing at the jailhouse' *(Powell v. Texas,* 392 U.S. 514, 529).
>
> * * *
>
> The moment that the program begins to serve the traditional purposes of criminal punishment, such as deterrence, preventive detention, or retribution, then the extended denial of liberty is simply no different than a prison sentence. . . ."

In *Humphrey v. Cady,* 405 U.S. 504 (1972) petitioner challenged the place and character of confinement in a correctional Sex Deviate Facility. He contended that commitment for what might "also amount to 'mental illness'" (at 512) to a state prison rather than a mental hospital, and the consequent denial of treatment for this condition,violated equal protection and due process. This Court found that he had raised "substantial constitutional claims".

Recently, in *Jackson v. Indiana,* 406 U.S. 715 (1972), this Court considered the commitment procedures in Indiana whereby an indicted person who was incompetent to stand trial was institutionalized. This Court again emphasized that civilly committed patients are entitled to treatment:

> ". . . we cannot say by virtue of his incompetency commitment Jackson has been denied an assignment [to an appropriate institution] or appropriate treatment to which those not charged with crimes would generally be entitled." 406 U.S. at 731 fn. 9.

This Court found that after a reasonable period of time had elapsed necessary to determine whether a substantial probability existed that the patient would attain capacity to stand trial in the foreseeable future, or would make progress toward recovery, the patient would have to be civilly committed or released. Even if it appeared that he would soon be able to stand trial, commitment could only be justified by progress towards that goal.

Further, this Court capsulized the essence of commitment for mental illness:

> "At the least, due process requires that the nature and duration of commitment bear some reasonable relation to the purpose for which the individual is committed." 406 U.S. at 738.

Since in civil commitment of the mentally ill, the purpose is treatment for mental illness, absent treatment, the nature of commitment would not be reasonably related to its purpose. Therefore, due process of law requires that treatment accompany institutionalization for mental illness.

Although this Court has not had frequent occasion to rule on the constitutional requirements of civil commitment,[4] as shown in the cases discussed above, this Court has repeatedly indicated that due process requires treatment as an essential requisite for civil involuntary hospitalization for mental illness.

With increasing frequency, courts across the country have begun to recognize a constitutional right to treatment for civilly institutionalized persons confined because of mental disability[5] or because of a status for which the person is confined.[6]

This trend is the result of more enlightened thinking on the issue, the opinions of this Court, and the considered examination of the issue by legal scholars and commentators.[7]

---

4. See *Jackson v. Indiana*, 406 U.S. at 737.

5. *Wyatt v. Stickney*, 325 F.Supp. 781 (M.D. Ala. 1971), *hearing ordered*, 334 F. Supp. 1341 (M.D. Ala. 1971), *enforced*, 344 F. Supp. 373 (M.D. Ala. 1972), *aff'd sub nom; Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), appears to be the most significant of these decisions. A constitutional right to treatment for involuntary civil patients has also been found in *Kesselbrenner v. Anonymous*, 33 N.Y.2d 161, 350 N.Y.S.2d 889 (1973); *Nason v. Superintendent*, 233 N.E.2d 908 (Mass. 1968); *Welsch v. Likens*, 373 F.Supp. 487 (D. Minn. 1974); *Rouse v. Cameron*, 373 F.2d 451 (D.C. Cir. 1966).

6. *Martarella v. Kelley*, 349 F. Supp. 575 (S.D.N.Y. 1972) *enforced*, 359 F. Supp. 478 (S.D.N.Y. 1973); *Inmates of Boys Training School v. Affleck*, 346 F. Supp. 1354 (D.R.I. 1972); *People v. Fuller*, 24 N.Y.2d 292, 300 N.Y.S.2d 102 (1969); *Stachulak v. Coughlin*, 364 F. Supp. 686 (N.D. Ill. 1973); *Nelson v. Heyne*, 491 F.2d 352 (7th Cir. 1974), *cert. denied*, 417 U.S. 976 (1974); *Morales v. Turman*, 364 F. Supp. 166 (E.D. Tex. 1973), 383 F. Supp. 53 (1974).

7. Note, *Developments in the Law — Civil Commitment of the Mentally Ill*, 87 Harvard Law Rev. 1190, 1316 (1974); Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); Symposium, *The Right to Treatment*, 57 Georgetown 673 (1969); Symposium, *The Mentally Ill and the Right to Treatment*, 36 Univ. Chi. Law Rev. 742 *et*

(Cont'd)

In the instant case, respondent has established to the satisfaction of the trier of fact that he had been deprived of treatment during his 14 years of incarceration at Florida State Hospital. He has, therefore, been deprived of his liberty and denied due process of law to which all persons are entitled under the Fourteenth Amendment.

(Cont'd)

seq. (1969); Note, *Due Process for All — Constitutional Standards for Involuntary Civil Commitment and Release*, 34 Univ. Chi. Law Rev. 633 (1967); Note, *The Nascent Right to Treatment*, 53 Univ. Va. Law Rev. 1134 (1967); Note, *Civil Restraint, Mental Illness, and the Right to Treatment*, 77 Yale L.J. 87 (1967).

CONCLUSION

For the foregoing reasons, the Committee submits that the decision below should be affirmed.

Respectfully submitted,

Simon Rosenzweig, Chairman
June Resnick German
Ronald N. Gottlieb
Alfred Berman
Members of the Sub-Committee on the Brief for the Amicus Curiae Committee on Mental Hygiene of the New York State Bar Association

MOTION FILED
JAN 15 1975

IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1974

* * *

NO. 74-8

* * *

J. B. O'CONNOR, M.D.,

Petitioner

V.

KENNETH DONALDSON,

Respondent

* * *

BRIEF OF THE STATE OF TEXAS, JOINED BY THE STATE OF TENNESSEE AND THE STATE OF UTAH, AS AMICI CURIAE IN SUPPORT OF PETITIONER

* * *

JOHN L. HILL
Attorney General of Texas

R. A. ASHLEY
Attorney General of Tennessee

VERNON B. ROMNEY
Attorney General of Utah

SUBJECT INDEX

PAGE

Caption 1

Jurisdiction 2

Summary of Argument 2

Argument 2

I. IT IS INAPPROPRIATE TO CAST THIS SUIT IN TERMS OF AN ACTION UNDER 42 U.S.C., SECTION 1983 BECAUSE THE SUPREME COURT HAS NEVER RECOGNIZED A CONSTITUTIONAL RIGHT TO TREATMENT FOR MENTAL PATIENTS 2

II. ESTABLISHMENT OF A CONSTITUTIONAL RIGHT TO TREATMENT IS AN UNWISE PROJECTION OF THE COURTS INTO OVERSIGHT AND ADMINISTRATION OF AN AREA OF LEGISLATIVE PREEMINANCE WHERE FUNDAMENTAL MEDICAL OPINION IS LACKING IN CONSENSUS 4

A. Criticism Of The Judicial Formulation Of A Right To Treatment Focuses On The Wide Difference of Professional Opinion As To What Constitutes Adequate Treatment. 5

B. Because The Medical Community Offers A Variety Of Treatment Concepts, The Proper Forum For

SUBJECT INDEX - CONTINUED

PAGE

Analyzing And Selecting A Particular Approach Is The Legislature . . 10

III. THE LOWER COURTS WERE IN ERROR IN IMPOSING PERSONAL LIABILITY IN THIS CASE 12

A. The Court's Imposition Of Personal Liability Is Inconsistent With The Doctrine Of "Good Faith" Or Quasi-Judicial Immunity 12

B. Imposition Of Personal Liability On Attending Physicians Is Likely To Produce Results Adverse To The Interests Of Improved Treatment In State Mental Institutions 19

CONCLUSION 21

SIGNATURE 21

CERTIFICATE OF SERVICE 22

INDEX OF AUTHORITIES

CASES PAGE

Burnham v. Department of Public Health of State of Georgia, 349 F.Supp. 1335 (M.D.Ga. 1972). 3, 4, 5

Clarke v. Cady, 358 F.Supp. 1156 (W.D.Wisc. 1973) 15

Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973). 15

Davis v. Watkins, CA No. 73-205, 12 (N.D. Ohio) 10

Donaldson v. Florida, 371 U.S. 806 (1962). . 18

Donaldson v. O'Connor, 234 So.2d 114 (Fla. 1969), cert.denied, 400 U.S. 869 (1970) 18

Donaldson v. O'Connor, 390 U.S. 971 (1968). 18

Donaldson v. O'Connor, 493 F.2d 507 (5th Cir. 1974). 19, 20

Eslinger v. Thomas, 476 F.2d 225 (4th Cir. 1973). 15

Huntt v. Government of Virgin Islands, 382 F.2d 38 (1967) 10

In re Donaldson, 364 U.S. 808 (1960) 18

Kenney v. Fox, 232 F.2d 288 (6th Cir. 1956), cert.denied 352 U.S. 855. 15

Pierson v. Ray, 386 U.S. 547 (1967). . 13, 14, 15 16, 17, 18

INDEX OF AUTHORITIES - CONTINUED

CASES — PAGE

Roe v. Wade, 410 U.S. 113 (1973). 8

Rouse v. Cameron, 373 F.2d 451 (D.C. Cir. 1966). 4, 7, 9

Skinner v. Spellman, 480 F.2d 539 (4th Cir. 1973) 15

Thomas v. Mississippi, 380 U.S. 524, 85 S.Ct. 1327 (1965) 13, 14

Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir. 1974) 19

CODES

Title 42 U.S.C., Section 1983. . . . . 2, 3, 4 12, 14, 16, 17

OTHERS

Bazelon, Implementing the Right to Treatment, 36 University Chicago Law Review 742 (1969). 7

Council of the American Psychiatric Association, Position Statement on the Question of Adequacy of Treatment, 123 American Journal Psychiatry 1458 (1967) 7

Current Psychiatric Therapies, Vols. 1-4 (J. Masserman Ed. 1961-64). 5

Katz, Right to Treatment - Legal Fiction, 36 University Chicago Law Review 755 (1969). 10

IN THE

SUPREME COURT OF THE UNITED STATES

October Term, 1974

* * *

J. B. O'CONNOR, M.D.,
Petitioner

V.

KENNETH DONALDSON,
Respondent

* * *

BRIEF OF THE STATE OF TEXAS, JOINED BY THE STATE OF TENNESSEE AND THE STATE OF UTAH, AS AMICI CURIAE IN SUPPORT OF PETITIONER

* * *

INTEREST OF AMICI CURIAE

Amici Curiae the States of Texas, Tennessee and Utah operate facilities for the treatment of the mentally ill pursuant to statutory enactments of the Legislatures of these states. Amici employ medical doctors, psychiatrists, and other professionals to administer such facilities and provide patient care. The decision of this Court in this matter will have a substantial impact upon the operations of the mental health facilities within the three states and could

affect the ability of amici to secure adequate professional personnel for the proper treatment of mentally ill patients within their care.

This brief is filed pursuant to Rule 42, Section 4, Rules of the Supreme Court of the United States.

SUMMARY OF ARGUMENT

Amici believe that the "right to treatment" found by the Fifth Circuit Court of Appeals below would be, if recognized by this Court, a right so difficult of application as to force lower federal courts into areas of medical practice and judgment, areas which the courts are particularly unsuited to administer. The field of medical treatment is uniquely inappropriate for the recognition of a new federal constitutional right.

If a federally protected right to treatment is announced by this Court, it should not be enforced in damages against individual doctors and other professionals who are employed in treatment programs which may be found to be violative of a right to treatment. Such an application under 42 U.S.C. Sec. 1983 is inconsistent with fundamental fairness and prior opinions of this Court. It would in addition make more difficult the already challenging problem of securing an adequate number of such professionals to serve in state operated mental facilities.

I. IT IS INAPPROPRIATE TO CAST THIS SUIT IN TERMS OF AN ACTION UNDER 42 U.S.C., SECTION 1983 BECAUSE THE SUPREME COURT HAS NEVER RECOGNIZED A CONSTITUTIONAL RIGHT TO TREATMENT FOR MENTAL PATIENTS.

An action under 42 U.S.C., Section 1983 will lie only when a person acting under color of state law has deprived another of a federally protected right. In the instant case, no federal statutory right is claimed, and no constitutional right has been recognized by the Supreme Court. The Burnham case, arising in Georgia, is quite similar to the case at hand. In Burnham the State of Georgia provided a statutory right to treatment for the mentally ill, but the court was unable to find that a similar federally protected right existed:

> "This court is of the opinion that plaintiffs have failed to demonstrate or sufficiently allege the deprivation of a federally protected right. Since plaintiffs have not been deprived of any federal right, they cannot maintain this action pursuant to 42 U.S.C., Sec. 1981, 1983 and 28 U.S.C., Section 1343(3) and (4). See City of Greenwood, Miss. v. Peacock, 384 U.S. 808, 86 S.Ct. 1800, 16 L.Ed.2d 944 (1966); Vasista v. Weir, 340 F.2nd 74 (3rd Cir., 1965); Stringer v. Dilger, 313 F.2nd 536 (10th Cir., 1963); Marshall v. Sawyer, 301 F.2nd 639 (9th Cir.,

1962). Burnham v. Department of Public Health of State of Georgia, 349 F.Supp. 1335, 1340 (M.D. Ga. 1972)."

In the instant case, as in Burnham, no deprivation of a federally protected right is evident. Without such a jurisdictional foundation an action under 42 U.S.C. Section 1983 cannot be sustained.

II. ESTABLISHMENT OF A CONSTITUTIONAL RIGHT TO TREATMENT IS AN UNWISE PROJECTION OF THE COURTS INTO OVERSIGHT AND ADMINISTRATION OF AN AREA OF LEGISLATIVE PRE-EMINANCE WHERE FUNDAMENTAL MEDICAL OPINION IS LACKING IN CONSENSUS.

Recent efforts in the mental health area to establish a right to "adequate treatment" and to set forth the criteria which would fulfill such a right raise serious questions about the nature and extent of judicial supervision which would be required. The central problem lies in the difficulty of setting forth a legal definition of "adequacy" based on medical expertise. Although the courts have occasionally involved themselves in difficult areas of social endeavor, the adoption of a right to treatment would be unwise since: (1) the possibility of setting forth meaningful criteria beyond the vague Rouse standards is at best questionable given the lack of consensus in the medical profession and the concomitant reliance of the courts upon medical evaluations; and (2) the responsibility for setting forth the conditions of confinement is properly a legislative function.

A. Criticism Of The Judicial Formulation Of A Right To Treatment Focuses On The Wide Difference Of Professional Opinion As To What Constitutes Adequate Treatment.

Because of the nature of mental illnesses, psychotherapy responds in many highly complex and often imprecise manners. The literature of psychotherapy is fraught with a bewildering array of schools of thought, theories and approaches. See Current Psychiatric Therapies, vols. 1-4 (J. Masserman Ed. 1961-64). The court in Burnham v. Department of Public Health of State of Georgia, supra, at 1343, indicated the perplexing problem confronting a court upon evaluation of the adequacy of treatment:

> "Common to each of the plaintiffs' characterizations of the alleged 'right' involved is the word 'treatment'. The dictionary provides meager assistance to the court in attempting to 'judicially define' what the breach of that duty would be, to wit:....conduct or behavior towards another party....(or) the action or manner of treating a patient medically or surgically. (Citation omit-

ted). Experts in the field of mental illness are also of little help other than in providing analogous terminology, e.g. 'therapy'. Defendants cite the following comments by Dr. Thomas W. Szaz (Professor of Psychiatry, State Univ. of N.Y.) in his article 'The Right to Psychiatric Treatment: Rhetoric and Reality', 57 Goe. L. J. 740, 741, (1969) as indicative of the problem:

'Levine (M. Levine, Psychotherapy in Medical Practice 17-19 (1942)) lists forty (40) methods of psychotherapy. Among these, he includes physical treatment, medicinal treatment, reassurance, authoritative firmness, hospitalization, ignoring of certain symptoms and attitudes, satisfaction of neurotic needs and bibliotherapy. In addition, there are physical methods of psychiatric therapy, such as the prescription of sedatives and tranquilizers, the induction of convulsions by drugs and electricity, and brain surgery. Obviously, the term 'psychiatric treatment' covers everything that may be done under medical auspices and more.

If mental treatment is all the things Levine and others tell us it is, how are we to determine whether or not patients in mental hospitals receive adequate amounts of it?" (emphasis added)

The vexing problem of defining "treatment" will arise every time an assessment of adequacy is put into issue. In Rouse three psychiatrists gave three different recommendations. Rouse v. Cameron, 373 F.2d 451, 459 (D.C. Cir. 1966). And as Judge Bazelon, has indicated, courts' experience with psychiatric testimony in other contexts raises faint hope about the clarity and usefulness of the testimony as a guide in a microscopic assessment of a course of treatment. Bazelon, Implementing the Right to Treatment, 36 U. Chi. L. 742 (1969).

Underscoring the difficulty is the arguably accurate reaction of the American Psychiatric Association to the Rouse decision that:

> "(t)he definition of treatment and the appraisal of its adequacy are matters for medical determination." Council of the American Psychiatric Assn., Position Statement on the Question of Adequacy of Treatment, 123 A. J. Psychiatry 1458 (1967).

Understanding that it is the medical profession which must, of necessity, supply the basic materials for evaluating treatment, the nature of such materials will necessarily control the efficacy of the evaluation. In the area of treatment, the nature of medical opinion is abundant and diverse -- consistency is not a virtue of the discipline.

The legal consequence of the diversity of professional opinion regarding the "adequacy" of treatment is that no judicial definition of a "right"

to treatment is possible. A right which is impossible to define and apply with any consistency is a right which is not amenable to judicial enforcement or protection. The Supreme Court has demonstrated its reluctance to base a legal right upon a illusory concept in its consideration of the "rights of unborn children" in Roe v. Wade, 410 U.S. 113 (1973). There the defendant State of Texas sought to justify its criminal abortion law as a protection of unborn children. The Court rejected that theory, observing that the rights of unborn children necessarily depend upon the question of when life begins. Faced with a mass of conflicting evidence and opinion -- religious, ethical, scientific, and medical -- on the question, the Court abandoned any attempt to define the legal right of the fetus and rather based its opinion upon the rights of the mother, rights capable of definition with real metes and bounds. Explaining its reluctance to judicially determine the rights of the unborn child, the Court declared:

> ". . . the law has been reluctant to endorse any theory that life, as we recognize it, begins before live birth or to accord legal rights to the unborn except in narrowly defined situations and except when the rights are contingent upon live birth." Id., at 731.

In other words, the Court would not define any legal right which was dependent for its definition upon such conflicting and ethereal evidence.

The court here should refrain from adopting

a legal right to "treatment" when the definition of that right depends upon a conflicting and confusing array of professional opinion. The right to "treatment" is even more difficult to define than the right to "life," because there is at least general agreement in the medical community as to the approximate time at which fetal life is capable of existence outside the mother's womb. No such comforting verity is available in the area of the treatment of mental patients.

The federal judiciary is not equipped to judge the adequacy of treatment for everyone who is involuntarily confined in the United States. The criteria set forth in Rouse, supra, indicate the nature of the problem of the court offering guidance to mental hospitals:

> (1) "The hospital need not show that the treatment will cure or improve (the patient) but only that there is a bona fide effort to do so." Id., at 456.
>
> (2) "The effort should be to provide treatment which is adequate in light of present knowledge." Id., at 456.
>
> (3) "Adequate staff and facilities must be provided." Id., at 457-58.

Obviously the articulation of these criteria offer little if any constructive guidance to the institutions

expected to abide by them. Additional judicial construction will be required before the Rouse criteria take on the aspect of meaningful objective parameters. Katz, Right to Treatment -- Legal Fiction, 36 U. Chi. L. Rev. 755, 780 (1969).

If this new constitutional right is established, the courts will be transformed into administrative bodies for proceedings involving the mentally ill. One recent case demonstrates that the courts will have to inject themselves into the everyday operation of mental health facilities in order to insure what the court perceives as adequate treatment; in Davis v. Watkins, the court went so far as to list twenty items which must be covered by the records on each patient's individualized treatment plan. Davis v. Watkins, CA No. 73-205, 12 (N.D. Ohio).

2. Because The Medical Community Offers A Variety Of Treatment Concepts, The Proper Forum For Analyzing And Selecting A Particular Approach Is The Legislature.

The court in Huntt v. Government of Virgin Islands, 382 F.2d 38, 44 (1967), articulated the doctrine of judicial restraint:

> "We should think that a court of law and equity would hesitate to interfere in the performance by a legislative body of its political and policy decisions which, in the absence of evidence to taint or fraud, have as their primary, if not sole, objective, the general well-being of the community then selected to represent."

Legislatures have historically served as the arbiters of the problem of safeguarding the welfare of the involuntarily confined. Broad directives based on conflicting authority will hamper this proper role of the legislature.

Since the finding of a right to treatment should be made on an individual, case by case basis, the legislature is the one body which is capable of assuring an administrative mechanism which will offer the most appropriate level of services to the mentally ill.

Also, in an effort to compel legislatures to spend more money on mental health facilities, the courts may destroy the effectiveness of those facilities by placing an unreasonably high price tag on treatment. The end result of adopting this new constitutional right could well mean that the state will be able to care for only the most dangerous psychotic, and those representing no threat to the public will be locked out of the mental health system. Another absurdity resulting from the affirmation of this decision would be that the states will have no choice but to free any person who is involuntarily confined if he refuses treatment.

The Donaldson case is especially important since it raises the prospect that an intermediate level of health professionals will be subject to per-

sonal financial ruin. This decision, if allowed to stand, will exacerbate an already chronic shortage of qualified mental health personnel. Few doctors and psychologists will want to subject themselves to continuous litigation as a condition of employment by the state governments. It is patently absurd to force mental health professionals, at their own risk, to justify a particular allocation of state resources.

III. THE LOWER COURTS WERE IN ERROR IN IMPOSING PERSONAL LIABILITY IN THIS CASE.

A. The Court's Imposition Of Personal Liability Is Inconsistent With The Doctrine Of "Good Faith" Or Quasi-Judicial Immunity.

Assuming this Court holds that there is a constitutionally protected right to treatment, are those medical professionals who have served as a part of a treatment program, which is subsequently found to be constitutionally infirm, subject to monetary damages under 42 U.S.C. Sec. 1983 without a complete showing of their personal culpability? Amici believe that the Court of Appeals committed a significant and potentially tragic error in holding that they are subject to such liability.

In effect, the lower court held that a doctor who remained at his post, treating patiente as best he could, was personally liable if that treatment, at a later time, was found to be qualitatively less than

would have been available had powers and instrumentalities completely and absolutely beyond his control intervened to provide the resources necessary to a higher quality treatment program. No prior opinion of this Court condones, much less compells, such an incredibly draconian result. The Court of Appeals has at once stated a new constitutional right and applied the remedy of personal liability to an individual who could not have foreseen such a right during a course of conduct which occurred inclusively before such a right was recognized.

This Court has written at length on the retroactive application of newly recognized rights. In Pierson v. Ray, 386 U.S. 547, 87 S.Ct. 1213, (1967), plaintiffs (Negroes) were arrested as they attempted to seat themselves in a "whites only" area of a Jackson, Mississippi bus terminal. They were subsequently convicted of violating a misdemeanor breach of the peace statute. On the trial de novo appeal to the county court, a directed verdict in favor of one of the plaintiffs was ordered; and the cases against the other plaintiffs were then dropped.

The process within the lower Mississippi courts resulted in the exoneration of the plaintiffs. They then filed a Section 1983 action against the original trial judge and several of the arresting police officers. After the initial conviction of the plaintiffs and before the filing of the civil rights action, the Mississippi breach of the peace statute under which the prosecutions had been brought was declared unconstitutional under similar facts in Thomas v. Mississippi, 380 U.S. 524, 85 S.Ct. 1327 (1965). Following a jury verdict in favor of the

plaintiffs against the judge and the policemen in Pierson, the Fifth Circuit Court of Appeals held that the judge was immune from liability under Section 1983 for conduct committed pursuant to his judicial functions. However, despite the fact that Thomas had been decided some four years after the arrests, the Fifth Circuit held that the policemen were nonetheless liable in a civil rights action for unconstitutional arrest. That court found good faith and probable cause for the arrests to exist, but those findings were of no help to these defendants in the Fifth Circuit.

This case, Pierson, was then reviewed by the Supreme Court of the United States; and the reasoning of the Fifth Circuit was not allowed to stand. Chief Justice Warren for eight members of the Pierson Court spoke clearly:

> "We hold that the defense of good faith and probable cause, which the Court of Appeals found available to the officers in the common-law action for false arrest and imprisonment, is also available to them under Section 1983." Pierson, supra, at 557.

Pierson restated a limited immunity for public police officers by way of the good faith and probable cause defense. The rationale for such immunity is simple enough: it would be basically unfair to require police officers and other public officials acting in good faith to become guarantors of the future course of constitutional development. See

Kenney v. Fox, 232 F.2d 288 (6th Cir. 1956), cert. denied 352 U.S. 855, 77 S.Ct. 84; Eslinger v. Thomas, 476 F.2d 225 (4th Cir. 1973); Skinner v. Spellman, 480 F.2d 539 (4th Cir. 1973); Clarke v. Cady, 358 F.Supp. 1156 (W.D. Wisc. 1973); Collins v. Schoonfield, 363 F.Supp. 1152 (D.Md. 1973).

As to the trial judge, the Pierson Court agreed with the Fifth Circuit that the judge was immune from liability for damages as a result of his conduct in finding the plaintiffs guilty of breach of the peace.

> "Few doctrines were more solidly established at common law than the immunity of judges from liability for acts committed within their judicial jurisdiction, as this Court recognized when it adopted the doctrine, in Bradley v. Fisher, 13 Wall 335, 20 L.Ed 646 (1872)." Pierson v. Ray, supra, at 553-554.

Justice Warren described the broad borders of the judicial immunity and its critical necessity:

> "This immunity applies even when the judge is accused of acting maliciously and corruptly, and it 'is not for the protection or benefit of the public, whose interest it is that judges should be at liberty to exercise their functions with independence and without fear of consequences.'

(Scott v. Stansfield, LR 3 Ex 220, 223 (1868), quoted in Bradley v. Fisher, supra, 349; note at 350, 20 L.Ed at 650). "Id. at 554.

The imposition of personal pecuniary liability or the threat of it, noted Justice Warren, ". . . would contribute not to principled and fearless decision-making but to intimidation." Id. at 554.

The facts of Pierson are strikingly similar in important detail to those before the Court in the instant case. The conduct of Dr. O'Connor was completely constitutional at the time it was committed. At no time while Dr. O'Connor and Mr. Donaldson were associated as doctor and patient at the Chattahoochee hospital did the law recognize a constitutional right to treatment for a patient involuntarily committed to a state mental institution. No doubt judicial immunity is unique in scope. However, application of the principles and rationale of such immunity requires the conclusion that it is of great importance, if quality care for mental patients in state facilities is important, that a medical doctor be reasonably free from the fear of personal liability as he practices in good faith the healing arts in the setting of an admittedly imperfect state mental institution.

Apparently, the Fifth Circuit in Donaldson and the Supreme Court in Pierson started from fundamentally different positions to reach conclusions regarding immunities under Section 1983. Justice Warren seems to imply in Pierson that as a general proposition, passage of Section 1983 left

fairly well intact common-law immunities and defenses:

> "The legislative record gives no clear indication that Congress meant to abolish wholesale all common-law immunities. Accordingly, this Court held in Tenney v. Brandhove, 341 U.S. 367, 95 L.Ed 1019, 71 S.Ct. 783 (1951), that the immunity of legislators for acts within the legislative role was not abolished." Id. at 554.

The Fifth Circuit, however, appears to presume that since Section 1983 does not specifically speak to the matter of immunities or defenses, ". . . the full range of officials' immunity available at common law do not apply in actions brought under Section 1983." Donaldson, supra, at 530.

Despite the Fifth Circuit's conclusion that the jury heard sufficient evidence to find a lack of good faith on the part of Dr. O'Connor, that conclusion is almost exclusively based upon the fact that another physician managed to spend more time with Mr. Donaldson than Dr. O'Connor did. If the evidence did not so overwhelmingly indicate that hospital and staff resources were so lacking that extra attention to one patient inevitably resulted in lack of attention to others, such evidence might be of some probative value. The fact that Dr. O'Connor did not ignore patients who did not spurn the treatment he offered in order to focus on Mr. Donaldson, who refused to accept the treatment that Dr.

O'Connor in his medical judgment felt was indicated, appears to have been decisive, and resulted in holdings by the trial court and the Fifth Circuit that Dr. O'Connor failed to show good faith.

It is clear that a basic element of the good faith defense in cases where previously lawful conduct has subsequently been found unconstitutional is the reasonableness of the actor's belief that his conduct is proper and lawful. In that regard, it is of more than passing interest that Dr. O'Connor's conduct had been at least impliedly approved in a lengthy series of right to treatment suits brought by Mr. Donaldson during the course of his stay at the Florida State Hospital. He was unsuccessful in each instance. Donaldson v. O'Connor, 234 So. 2d 114 (Fla. 1969), cert. denied, 400 U.S. 869 (1970); Donaldson v. O'Connor, 390 U.S. 971 (1968); Donaldson v. Florida, 371 U.S. 806 (1962); In re Donaldson, 364 U.S. 808 (1960). Dr. O'Connor had absolutely no reason to believe that his conduct would later be judged retroactively by a new and unknown standard. It is difficult to imagine a situation in which a treating doctor could be more innocent of future constitutional development. Yet, the Fifth Circuit has cast the burden of its landmark decision on the shoulders of Dr. O'Connor. The result is wholly inconsistent with the holding and rationale of Pierson. Amici believe that the Fifth Circuit's treatment of the good faith defenses and immunities is superficial. Indicative of that superficiality is its apparent conclusion that because the defendants at trial failed to properly object to the trial court's inherently contradictory instruction on the good faith defense, a proper

consideration of it was somehow made by the jury. Indeed, amici submit that the jury instruction approved by the Fifth Circuit practically precluded a physician, working under conditions similar to those faced by Dr. O'Connor, from showing good faith. Donaldson v. O'Connor, 493 F.2d 507 at 527. It is unacceptable for the Court of Appeals to establish a broad and significant principle of law based upon a failure to enter a proper objection.

B. Imposition Of Personal Liability On Attending Physicians Is Likely To Produce Results Adverse To The Interests Of Improved Treatment In State Mental Institutions.

The Circuit Court's decision in this case is based upon its view that Mr. Donaldson received inadequate treatment at the Florida State Hospital. The decisions in Donaldson and in Wyatt v. Aderholt, 503 F.2d 1305 (5th Cir., 1974) are, of course, judicial efforts to insure that treatment of involuntarily committed patients in state institutions is constitutionally adequate. The imposition of personal liability on doctors working within those institutions is not likely to improve treatment but is more likely to frustrate this objective.

In the case at bar, Dr. O'Connor worked within a hospital with admittedly limited resources. He was powerless to increase the appropriations for patient care; and he was likewise impotent to enlarge the medical staff of the hospital, to bring the staff-patient ratio more closely in line with the

demands of a large patient population. These responsibilities were and are the province of others. Unless and until the Legislature of the State of Florida determines that patient treatment at the Florida State Hospital at Chattahoochee will be improved and provides the resources for such improvement, improvement will not come regardless of what Dr. O'Connor and his collegues do within the institutions. This elemental fact has been ignored by the Fifth Circuit. Imposition of a personal judgment on Dr. O'Connor will add no additional psychiatrists to the staff at Chattahoochee. It will provide no additional psychologists, registered nurses, rehabilitation specialists, or attendants. It will provide no treatment programs, no new facilities. It will improve the treatment at Chattahoochee not at all. The decision means only that one more psychiatrist, desperately needed, can no longer afford to practice his art in a state hospital.

Indeed, Donaldson will surely exacerbate the problem of finding and hiring qualified medical professionals, a problem faced by every state operated mental institution. The services of psychiatrists are secured on a seller's market. It is no exaggeration to suggest that this decision will make psychiatrists harder to find. Few psychiatrists or medical doctors will be able to afford the luxury of potential personal liability for the sins of others, and the lot of the patients within these facilities will be made no better.

CONCLUSION

The Court should not recognize a federally guaranteed right to treatment under the United States Constitution. If the Court should hold such a right to exist, the Court should not affirm the lower courts' holding of personal liability against Dr. O'Connor.

Respectfully submitted,

JOHN L. HILL
Attorney General of Texas

DAVID M. KENDALL
First Assistant Attorney General
of Texas

THOMAS W. CHOATE
JOE T. HICKEY
M. LYNN TAYLOR
Assistant Attorneys General
of Texas

R.A. ASHLEY
Attorney General of Tennessee

VERNON B. ROMNEY
Attorney General of Utah

CERTIFICATE OF SERVICE

I, David M. Kendall, First Assistant Attorney General of Texas, Attorney for Amici, certify that a copy of the above and foregoing Brief of Amici has been served upon the parties hereto by depositing same in the United States Mail, Air Mail Postage Prepaid, addressed to each as follows: Honorable Robert L. Shevin, Attorney General of Florida, Attorney for Petitioner, Office of the Attorney General, The Capitol, Tallahassee, Florida 32304; Mr. George Dean, Attorney for Respondent, P. O. Box 248, Destin, Florida 37541; Mr. Bruce J. Ennis, Attorney for Respondent, 84 Fifth Avenue, New York, New York 10011.

DAVID M. KENDALL
First Assistant Attorney General
of Texas

Supreme Court, U. S.
FILED
FEB 5 1975
MICHAEL RODAK, JR., CLERK

IN THE
SUPREME COURT OF THE UNITED STATES

October Term, 1974

No. 74-8

J. B. O'CONNOR, M.D.,
Petitioner,

-v-

KENNETH DONALDSON,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES
COURT OF APPEAL FOR THE FIFTH CIRCUIT

REPLY BRIEF FOR THE PETITIONER

ROBERT L. SHEVIN
Attorney General

DANIEL S. DEARING
Special Assistant Attorney General

RAYMOND W. GEAREY
Assistant Attorney General

The Capitol
Tallahassee, Florida 32304

January 31, 1975

SUBJECT INDEX

Page

Facts..... 1

Argument..... 3

Conclusion.....24

Appendix

CITATIONS

Cases: Page

Briscoe v. Kusper,
435 F.2d 1046, 1057-58
(5th Cir. 1970).....21

Collins v. Schoonfield,
363 F.Supp. 1152, 1156
(D.Md. 1973).....20

Doe v. McMillian,
412 U.S. 306, 320 (1973).....16, 22

In re Donaldson,
364 U.S. 808 (1960).....18

Donaldson v. Florida,
371 U.S. 806 (1962).....18

Donaldson v. O'Connor,
390 U.S. 971 (1968).....18

Donaldson v. O'Connor,
234 So.2d 114 (Fla. 1969),
cert. den., 400 U.S. 869 (1970)...18

Eslinger v. Thomas,
476 F.2d 225, 229 (4th Cir. 1973).20

Gaffney v. Silk,
488 F.2d 1248, 1250
(1st Cir. 1973).....16

Handverger v. Harvell,
479 F.2d 513, 516 (9th Cir.),
cert. den., 414 U.S. 1972 (1973)..22

Harrison v. Brooks,
446 F.2d 404, 407 (1st Cir. 1971).22

Heines v. Kerner,
492 F.2d 937, 941
(7th Cir. 1974.....20

Hoffman v. Halden,
268 F.2d 280 at 301 (9th Cir. 1959).11

Jackson v. Indiana,
406 U.S. 715 (1972).....6

Jannetta v. Cole,
493 F.2d 1334, 1338
(4th Cir. 1974).....21

Jones v. Parrigan,
459 F.2d 81, 83 (6th Cir. 1972)...22

Mitchell v. Boslow,
357 F.Supp. 199, 202-203
(D.Md. 1973).....22

Pierson v. Ray, 15, 18
386 U.S. 547 (1967).....20
386 U.S. at 557.....15

Roberts v. Williams,
456 F.2d 819, 831 (5th Cir.),
cert. den., 404 U.S. 866 (1971)...16

Scheuer v. Rhodes,
416 U.S. 232 (1974).....15

Schmidt v. Wingo,
499 F.2d 70 (6th Cir. 1974),
affirming 368 F.Supp. 727 (W.D.
Ky. 1973).....22

Silber v. United States,
370 U.S. 717, 718 (1962).....24

Smith v. Losee,
485 F.2d 334, 342 (10th Cir. 1973)
(en banc).....22

Solesbee v. Balkom,
390 U.S. 9, 24-25 (1950).....10

Strickland v. Inlow,
485 F.2d 186, 191 (8th Cir. 1973),
cert. granted sub nom......21

United States v. Atkinson,
297 U.S. 157, 160 (1936).....24

Westberry v. Fisher,
309 F.Supp. 12, 17 (D.Me. 1970)...18

Wood v. Strickland, cert granted,
94 S.Ct. 1932 (No. 73-1285, 17,
Apr. 15, 1974).....21

Wyatt v. Aderholt,
503 F.2d 1305 (5th Cir. 1974).....11

Wyatt v. Stickney,
325 F.Supp. 781.....19

People ex rel. Anonymous v.
LaBurt, 14 App.Div. 2d 560,
218 N.Y.S.2d 738 (1961),
appeal dismissed and cert.
denied, 369 U.S. 428 (1962).....18

Florida Statutes:

§394.459.....5

§394.459(2)(4).....4

§394.459(13).....4

§394.467.....4, 5

Law Reviews, Books and Articles:

American Psychiatric Association
Position Statement on the Question of Adequacy of Treatment, 123 Am.J.Psychiat 1458, 1459 (1967).....8

Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960).....18

Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974).....8, 9

Friedman and Kaplan, *The Comprehensive Textbook of Psychiatry*, p. 1436 (1967).....8

Roberts, *Some Observations on the Problems of the Forensic Psychiatrist*, 1965 Wis.L.Rev. 240, 244 (1965).....8

FACTS

The only important factual dispute that has arisen on appeal concerns whether the evidence supported the jury finding of dangerous. This issue should actually be irrelvant because dangerousness was not the sole criterion for commitment in Florida from 1957-1971 (A 243-256).

There was conflicting evidence at trial of Donaldson's propensity for violence. (A 3, 64-72, 81, 120-121, 131-133, 136, 149-150, 188(b), 196(a), 22[illegible], 232, 233, 235, 241(a)). Petitioner O'Connor firmly believed, in his professional opinion, that Donaldson was dangerous. Others disagreed.

Petitioner believes that the issue of psychiatric diagnosis of dangerousness should not have been subjected to jury review. Leading articles such as Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974), teach us that psychiatrists cannot be expected to accurately predict dangerous behavior:

> One psychiatrist has noted that there is no emperical support for the belief that psychiatrists can predict dangerous behavior. To the contrary, even with the most careful, painstaking, laborious and lengthy clinical approach to the prediction of dangerousness, false positives may be a minimum of 60 to 70%. In other words,

> even under controlled conditions, at least 60 to 70% of the people whom psychiatrists judge to be dangerous may, in fact, be harmless. 62 Cal.L.Rev. 693 at 714.

The record shows little concrete evidence of dangerous behavior of Kenneth Donaldson during his hospitalization and might be said to support the jury verdict. However, in light of documented statistics which demonstrate the fallibility of psychiatric opinions of dangerousness, should Dr. O'Connor be made to answer in damages for the excercise of his professional judgment on that issue? Petitioner submits that the jury should not have been presented with this issue and that regardless of whether Donaldson was dangerous or not, he should not have been made to answer in damages for a decision made in the day-to-day exercise of his professional judgment.

I.

THE PROPOSED CONSTITUTIONAL RIGHT TO TREATMENT IS INCAPABLE OF ADEQUATE DEFINITION AND EFFECTIVE APPLICATION.

Petitioner does not quarrel with the proposition that persons involuntarily civilly committed to a state mental hospital are entitled to adequate treatment. However, the constitutional right to treatment, as stated by the Court of Appeals for the Fifth Circuit is a futile right incapable of definition or application which would adequately protect a patient who would seek to enforce it. At the same time, the right, as declared by the Court of Appeals, places an unreasonably heavy burden upon the attending physicians and hospital administrators who must answer for their day-by-day diagnostic and course-of-treatment decisions. Petitioner does not argue that the treatment decisions of psychiatrists should never be subject to judicial review, but does argue that the effect of the decision of the Court of Appeals is to allow the federal courts to subject psychiatric decisions to far greater scrutiny than is possible given the amorphous nature of psychiatry.

As discussed at oral argument, the State of Florida adopted a new mental health law in 1972, known as the Baker Act. Although the new statutory provisions are not at issue in this case, the Baker Act is set out in the Appendix of this Reply Brief for convenience of the Court.[1] Florida, by

---

[1] R.A. at 1.

adoption of the Baker Act, implemented a sweeping declaration of patient rights, including a statutory right to treatment[2] which guarantees quality treatment suited to the needs of the individual patient. A hearing examiner conducts a periodic review of each patient's need for hospitalization and treatment.[3] Finally, a section of the Baker Act provides for monetary liability of any person who wilfully violates or abuses the statutory rights or privileges of patients, providing, however, immunity from liability for one who acts in good faith during his actions in connection with the admission, diagnosis, treatment or discharge of a patient.[4]

The new Florida Statutory scheme notwithstanding, Petitioner would argue that the step from a recognition of a right to treatment to a *constitutional* right to treatment is a step which must traverse a wide chasm, that chasm being a definition of what constitutes adequate treatment within the meaning of the proposed right, and the lack of guidelines for enforcement of the right by the federal judiciary.

It has been argued by Respondent that Petitioner's argument that the proposed constitutional right is non-justiciable must fail because the Florida Legislature

---

2 §394.459(2)(4), Florida Statutes; RA at 8-9.

3 §394.467, Florida Statutes; RA at 20.

4 §394.459(13), Florida Statutes; RA at 12.

has established a definable statutory right to treatment, as discussed above. Respondent's argument in that regard has a ring of validity until one examines the scope of review as envisioned by the Florida Legislature as compared to that available under the holding of the Court of Appeals in this case. Section 394.459, Florida Statutes,[5] provides for a right to skillful quality treatment suited to the needs of the patient, and requires patient consent to treatment. The scope of review is impliedly limited to whether, as suggested by Respondent at page seventy of his Brief, the treatment in question lies "within a professionally accepted range of treatment modes."[6] On the other hand, the decision of the Court of Appeals goes far beyond the standards suggested by Respondent and implies that a federal court may order that some treatment modes are improper or ineffective and require an alternate course of treatment. Such judicial discretion removes treatment decisions from trained psychiatrists and places them upon the shoulders of a federal judge and/or jury. Petitioner is concerned by the prospect of federal courts doing as the Court of Appeals did when it declared that "mileau therapy", a professionally accepted

---

5 RA at 8.

6 §394.467, Florida Statutes; RA at 20-26.

treatment mode, is but an evasive response used by doctors to avoid accusations of inadequate treatment, citing a law review article by a lawyer as authority.[7] Such judicial encroachment into professional decisions is not only improper but has the effect of placing any psychiatrist henceforth employing "mileau therapy" in an unnecessarily vulnerable position. Thus, the Court of Appeals has not limited the review of the federal judiciary to the question of whether professionally permissable care was provided, but has allowed a more intensive, utterly unacceptable, review of the desirability of one permissable treatment mode over another.

Petitioner argues that the right as stated by the Court of Appeals must fail, not because mental patients are not entitled to treatment, but because a *constitutional* right to treatment absent adequate judicial guidelines is a right incapable of meaningful, just enforcement. Such a right cannot truly be a right at all.

Petitioner accepts and agrees with this Court's view in *Jackson v. Indiana*, 406 U.S. 715 (1972), that the nature and duration of confinement must bear some reasonable relation to the purpose for which the person is committed. Petitioner further agrees that if there is a constitutional right to treatment, that it is not an express right but must flow from the due process clause of the Fourteenth Amendment.

---

[7] 493 F.2d at 511.

Assuming there is a constitutional right there, its application must involve two separate inquiries. First, the commitment process must be examined for elements of due process. Second, there must be an investigation of whether the patient is receiving treatment appropriate to his disorder. If both inquiries are answered in the affirmative, requirements of due process should be satisfied. The Court of Appeals envisioned a far broader inquiry into whether the patient was receiving the best possible treatment rather than permissable treatment.

If we apply the above rationale to Donaldson's case, we find that there is little question that Donaldson was ill at the time of his commitment and that the statutory commitment procedures were followed. Donaldson's commitment complied with all requirements of due process under 1957 standards. We must then proceed to examine his treatment. Petitioner submits that Donaldson received all treatment available at Florida State Hospital, which was appropriate to his disorder, and to which he would submit.[8]

The right to treatment as announced by the Court of Appeals demonstrates the difficulty of enforcement when it comes time to review the treatment

---

[8] A at 25, 37-38, 52, 75-76, 95-96, 114-115, 118, 122-126, 145, 152, 166, 195, 199, 200, 200(a), 201(a)(ii), 202(i), 202(b), 202(c), 203(a), 203(i), 204, 204(a), 204(b), 205-206(i).

rendered an individual patient. A bewildering number of variables must be considered when judging any patients treatment. These must include, at the least, consideration of: (1) the wide variety of psychiatric schools of thought and treatment;[9] (2) the inexac nature of psychiatry and psychiatric testimony;[10] patient cooperation;[11] and the nature of the disease.[12] The Court of Appeals left little room for many of these considerations. Yet all of these are crucial to the determination of whether a particular patient has received proper treatment.

Respondent argues that expert testimony of psychiatrists should be adequate to judge treatment. However, other sources, including an article written by Respondent's counsel, demonstrate that the science of psychiatry is far from exact and too

---

9 Roberts, *Some Observations on the Problems of the Forensic Psychiatrist*, 1965 Wis.L.Rev. 240, 244 (1965).

10 Ennis and Litwack, *Psychiatry and te Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (174).

11 American Psychiatric Association, *Position Statement on the Question of Adequacy of Treatment*, 123 Am.J.Psychiat 1458, 1459 (1967).

12 Friedman and Kaplan, *The Comprehensive Textbook of Psychiatry*, p. 136 (1967).

unreliable to be of benefit as expert testimony in the courtroom.[13] The Ennis and Litwack article suggests that diagnostic decisions of psychiatrists disagree at an alarming rate:

> Actually, as we shall see, the reliability of psychiatric judgments of specific diagnostic categories (schizophrenia, paranoid type, depressive reaction, passive-agressive personality, and so on) is even lower--somewhere in the neighborhood of 40 percent. In other words, if a first psychiatrist testifies that a prospective patient suffers from involuntary melancholia or some other specific, non-organic diagnosis, it is more likely than not that a second psychiatrist would disagree.[14]

Ennis and Litwack note further that psychiatric predictions of success of a particular treatment mode are equally unreliable:

> Robbins and Guze surveyed the literature concerning the validity of clinician's judgments of the prognosis of schizophrenic patients. They found considerable variations between the predicted prognosis and the actual outcomes of treatment. In practice, patients who received a poor prognosis did poorly as

---

13 Ennis and Litwack, *Psychiatry and the Presumption of Expertise: Flipping Coins in the Courtroom*, 62 Cal.L.Rev. 693 (1974).

14 62 Cal.L.Rev. 693 at 702.

> infrequently as 55 percent of the time in one study and as frequently as 91 percent of the time in another. In contrast, patients with a good prognosis did well as frequently as 83 percent of the time in one study and as infrequently as 36 percent in another.
>
> Other investigations showed that psychiatrists accurately predicted the beneficial or nonbeneficial effect of electro-shock therapy for several hundred patients only 41 percent of the time. In other words, their predictions would have been more valid if they had been based on the flip of a coin.[15]

Faced with such statistics it is difficult to imagine allowing a federal court jury to evaluate treatment and punish a psychiatrist for having failed in prescribing a more successful course of treatment. Psychiatry remains a science of "tentative and dubious knowledge as to mental disease "with" great strife in schools in regard to them" as noted by Justice Frankfurter in *Solesbee v. Balkom*, 339 U.S. 9, 24-25 (1950). Justice Frankfurter's concern over the "treacherous uncertainties in the present state of psychiatric knowledge" should guide this Court to the realization that the very nature of psychiatry prohibits enforcement of a *constitutional* right to treatment on the individual level as in this case.

---

15 62 Cal.L.Rev. 693 at 719.

While enforcement of the proposed right may be impossible on the individual level, enforcement of a general right to treatment on the institutional level, such as in *Wyatt v. Aderholt*, 503 F.2d 1305 (5th Cir. 1974), may have similar difficulties. Such enforcement does not guarantee adequate treatment on the individual level and solve the problems of this case; the institutional course does guarantee a more adequate level of care to all patients.

II.

DR. O'CONNOR SHOULD NOT HAVE BEEN FOUND TO BE PERSONALLY LIABLE FOR HIS DECISIONS NOT TO RELEASE DONALDSON.

It has been argued by Respondent that Dr. O'Connor was properly held liable for a series of refusals to restore Respondent Kenneth Donaldson to his liberty "either by treatment or release."

Petitioner submits that he was entitled to immunity for his quasi-judicial decisions not to release Kenneth Donaldson, a patient committed by judicial order. Dr. O'Connor's decisions not to release Kenneth Donaldson must be considered to have been of a quasi-judicial nature. This theory was raised before the trial court, is not new to the law, and was the basis of the decision in *Hoffman v. Halden*, 268 F.2d 280 at 301 (9th Cir. 1959). This theory was, however, rejected by the Court of Appeals when raised by a co-Appellant, Dr. Gumanis.

In the alternative, Petitioner submits that the doctrine of good-faith should have been applied to insulate him from liability. This defense was raised before the trial court. However, the trial court rejected Petitioner's requested jury instruction and gave an instruction written by the Court (A 184-85):

> Now, the Defendants in this action have claimed and are relying on the defense that they acted in good faith. Simply put, the Defendants contend they in good faith believed it was necessary to detain Plaintiff in the Florida State Hospital for treatment for the length of time he was so confined.
>
> If the Jury should believe from a preponderance of the evidence that the Defendants reasonably believed in good faith that detention of Plaintiff was proper for the length of time he was so confined then a verdict for Defendants should be entered even though the Jury may find the detention to have been unlawful.
>
> However, mere good intentions which do not give rise to a reasonable belief that detention is lawfully required cannot justify Plaintiff's confinement in the Florida State Hospital.
>
> As a corollary Plaintiff here need not show malice or ill-will to prove his action under the Civil Rights Act. All that is required is that he demonstrate state action which amounts to an actual deprivation of constitutional rights or other rights guaranteed by law.
>
> As to this defense of good faith, the burden is upon the Defendants to prove this defense by a preponderance or a greater weight of the evidence in the case. (e.s.)

Although this instruction was never objected to by Petitioner's counsel at trial, it is clearly a very misleading and improper instruction. It seems to say that good faith is a defense, but is not a defense. The confusing effect of such wording on the jury can be easily imagined.

The jury instruction aside, the evidence cannot be read to demonstrate bad faith on Dr. O'Connor's part. Dr. O'Connor relied heavily upon staff opinion, and the record reflects that decisions to refuse release were not Dr. O'Connor's alone. The staff conference of April 2, 1962, shows four doctors in agreement. (A 194). The conference report of January 9, 1964, shows similar agreement (A 195), as does that of March 21, 1968, with the exception that the staff recommended trial visits or out-of-state release (A 197). Dr. O'Connor is clear from aspersions of bad faith or malice in regard to decisions not to grant the recommended trial visits or out-of-state release. The record shows Donaldson had repeatedly refused trial

visits (A 152), and out-of-state release was considered inappropriate. (A 131, 164). Psychological testing, when not refused by Donaldson, (A 234), showed a similar consensus of opinion that Donaldson was ill and should not be released (A 230-241(a)). An exception to that series was the final test which ultimately lead to Donaldson's release.

The opinion of an outside psychologist, Dr. Calhoun, also supported Dr. O'Connor's actions. (A 222). Dr. O'Connor's judgment was further vindicated by the refusal of the state and federal courts to order Donaldson's release on some fifteen to twenty occasions from 1957 to 1970. Available information on several of those cases is contained in the Appendix to this Reply Brief, as requested by Mr. Justice Blackmun.

Dr. O'Connor's testimony, by depositions and interrogatories, supports the view that he relied on the reports of Donaldson's attending physicians and consensus of staff opinion (A 127, 129, 130, 131, 132, 133, 134, 136, 137, 165, 166, 169, 170).

The Court should also consider the evidence concerning inadequate staffing of Florida State Hospital during the time period in question. The record shows that the case loads were fifteen times heavier than current American Psychiatric Association standards. In addition, the physicians were required to spend nearly one-half of their time on administrative duties, leaving an average of two minutes per patient per

week for treatment, observation, etc. However, the record further shows Dr. O'Connor's efforts during his tenure as Superintendent to improve care and conditions. (A 167-69).

Respondent also points to Dr. O'Connor's occasional denials of such things as grounds privileges but conveniently overlooks evidence that grounds privileges were rejected because Donaldson had on one occasion attempted to escape from the hospital. (A 118, 127).

Further evidence of Dr. O'Connor's good-faith treatment comes from the mouth of Respondent who testified that he believed that Dr. O'Connor respected his belief in Christian Science and that Dr. O'Connor had told him that he would not be forced to accept medication unless he became a behavior problem. (A 52).

This Court has emphasized repeatedly that state officials should not be liable personally for damages when they have acted in good faith in the performance of their duties. In *Pierson v. Ray*, 386 U.S. 547 (1967), the Court held that plaintiffs could not recover damages from individual police officers for an unconstitutional arrest "if the jury found that the officers reasonably believed in good faith that the arrest was constitutional." *Id.* at 557. Similarly, this Court in *Scheuer v. Rhodes*, 416 U.S. 232 (1974), made clear that this "qualified immunity" not only extends to more senior state officials, but in fact should be broader

as the defendant's "scope of discretion and responsibilities" is broader. *Id.* at 247. *See also Doe v. McMillian*, 412 U.S. 306, 320 (1973).

The official immunity doctrine "seeks to reconcile two important considerations--

> '[O]n the one hand, the protection of the individual citizen against pecuniary damage caused by oppressive or malicious action on the part of [government officials]; and on the other, the protection of the public interest by shielding responsible governmental officers against the harassment and inevitable hazards of vindictive or ill-founded damage suits brought on account of action taken in exercise of their official responsibilities.'" [*Doe v. McMillan*, *supra*, 412 U.S. at 319, *quoting* *Barr v. Matteo*, 360 U.S. 564, 565 (1959).]

One court has summarized the doctrine as allowing "a qualified immunity based on good faith performance of duty as the officials understood it." *Roberts v. Williams*, 456 F.2d 819, 831 (5th Cir.), *cert. denied*, 404 U.S. 866 (1971); *accord*, *e.g.*, *Gaffney v. Silk*, 488 F.2d 1248, 1250 (1st Cir. 1973). Thus, the defense consists of two basic elements. First, courts must focus on the official's understanding of his or her duty; the courts will consider the defense in light of that understanding, so long as it is reasonable, even if

incorrect. The second element[17] of the defense provides immunity when the official made a good faith effort to meet that duty, as so understood, even if the effort was unsuccessful.

Regarding the first part of the defense, the law is well settled that a state official should not be held personally liable for a civil rights violation when he or she had tried in good faith to follow then-existing constitutional principles, even

---

[17] In a case where the definition of defendant's legal duty is clear, only the latter element of the defense is relevant. In the instant case, however, where the constitutional contours of the duty are still developing, the two elements are interrelated. Thus, defendant's good faith effort must be measured against whatever legal duty he reasonably should have know was applicable. The question of whether an objective or subjective standard is appropriate in assessing whether a defendant made such a "good faith effort" is now pending before the Court in *Wood v. Strickland*, *cert. granted*, 94 S.Ct. 1932 (No. 73-1285, Apr. 15, 1974).

if those principles later were overturned. As this Court held in *Pierson v. Ray*, *supra*, 386 U.S. at 557, state officers are not "charged with predicting the future course of constitutional law." They "neither can nor should be expected to be seers in the crystal ball of constitutional doctrine." *Westberry v. Fisher*, 309 F.Supp. 12, 17 (D.Me. 1970).

In the instant case, a constitutional right to treatment was little more than a gleam in the eye of its most ardent proponent during Mr. Donaldson's confinement, which began in 1957. The article generally credited as the first even to suggest such a right appeared in 1960. Birnbaum, *The Right to Treatment*, 46 A.B.A.J. 499 (1960); *see* 493 F.2d at 519-20 & nn.12, 14. Several courts during the 1960's refused to recognize the existence of a constitutional right to treatment. *See, e.g., People ex rel. Anonymous v. LaBurt*, 14 App.Div. 2d 560, 218 N.Y.S.2d 738 (1961), *appeal dismissed and cert. denied*, 369 U.S. 428 (1962). Indeed, Mr. Donaldson himself brought several earlier right-to-treatment claims against Dr. O'Connor, and the courts consistently rejected these claims. *See, e.g., Donaldson v. O'Connor*, 234 So.2d 114 (Fla. 1969), *cert. denied*, 400 U.S. 869 (1970). *See also Donaldson v. O'Connor*, 390 U.S. 971 (1968); *Donaldson v. Florida*, 371 U.S. 806 (1962); *In re Donaldson*, 364 U.S. 808 (1960). It was not until 1971, the year of Mr. Donaldson's release from Chattahoochee, that the first court held that there was a constitutional

right to treatment. *Wyatt v. Stickney*, *supra*, 325 F.Supp. 781.

Not only is the constitutional right to treatment a recent development, but the past decade has also seen major changes in the professional approach toward psychiatric treatment of the seriously mentally ill. Beginning in the 1960's psychiatrists began to recognize that long-term custodial care of the mentally ill, in large and dehumanizing institutions situated in isolated settings, was often counterproductive and therefore should be resisted. Many patients--even those with the most serious mental illness (such as that diagnosed in Mr. Donaldson's case)--could be rapidly returned to home and community. This approach was made possible in part by the advent of effective medications which moderated the symptoms and allowed patients to be managed in the community.

With or without such medications the fundamental approach to most of these patients has now been modified, and every attempt is made to return them to home, family, work, and community as soon as possible.

Mr. Donaldson was originally hospitalized at a time when the community mental health approach had not been clearly formulated or generally accepted. Much of the testimony given in his case assumes the general acceptance of the community mental health approach without recognizing the changes which were occurring in psychiatry during that period.

Thus, not only was Dr. O'Connor judged by a new legal standard, but also his approach to treatment was measured in terms of a new psychiatric perspective.

Under these circumstances it is unfair and contrary to the principle this Court stated in *Pierson v. Ray* to apply the right-to-treatment principle retroactively by holding psychiatrists personally liable for damages dating back many years before they could have known of this new constitutional duty.

Respondent argues that this issue was never raised below. Petitioner must disagree. The issue was raised in pre-trial motion practice, through Defendants proposed Jury Instruction No. 15 which was denied, and in a Post-Argument Memorandum filed at the request of the Court of Appeals. Other Circuits have recognized the necessity of "providing conscientious state officials with some protection against the cutting edge of a rapidly developing legal doctrine."[18]

As stated in *Collins v. Schoonfield*, 363 F.Supp. 1152, 1156 (D.Md. 1973), "it would contravene basic motions of fundamental fairness if officials were held to be liable monetarily for acts which they could not reasonably have known were unlawful."

---

18 *Eslinger v. Thomas*, 476 F.2d 225, 229 (4th Cir. 1973); *Heines v. Kerner*, 492 F.2d 937, 941 (7th Cir. 1974).

Equitable relief, of course, should always be available to insure compliance with newly developing legal standards. *See Jannetta v. Cole*, 493 F.2d 1334, 1338 (4th Cir. 1974):

> ...while there is nothing in §1983 or the fourteenth amendment to suggest that an improper motive is requisite for a federal cause of action, conscientious state officials, when acting reasonably and in good faith, should not be expected to answer in money damages for failure to accurately predict the future course of constitutional doctrine, even though such failure may entitle a plaintiff to equitable relief.

See also Briscoe v. Kusper, 435 F.2d 1046, 1057-58 (7th Cir. 1970). Thus, the good faith defense in no way defines the right; it simply limits the remedy to equitable relief and to damages against the institution or officials who have not acted in good faith.

The second element of the good faith defense that should be available in cases such as this would forbid personal liability whenever the doctor makes a good faith, even if unsuccessful, effort to meet the duty he or she reasonably understands is owed to the patient. Numerous courts have applied this qualified immunity principle to a wide variety of official positions. *See, e.g., Strickland v. Inlow*, 485 F.2d 186, 191 (8th Cir. 1973), *cert. granted sub nom. Wood v. Strickland*, 94 S.Ct. 1932 (No. 73-1285,

Apr. 15, 1974)(school board members); *Handverger v. Harvill*, 479 F.2d 513, 516 (9th Cir.), *cert. denied*, 414 U.S. 1072 (1973)(university officials); *Jones v. Perrigan*, 459 F.2d 81, 83 (6th Cir. 1972)(FBI agent); *Harrison v. Brooks*, 446 F.2d 404, 407 (1st Cir. 1971)(town officials); *Mitchell v. Boslow*, 357 F.Supp. 199, 202-203 (D.Md. 1973)(director of state institution for "defective delinquents"). The principle is at least equally applicable to staff psychiatrists and hospital officials, whose "scope of discretion and responsibilities" is necessarily broad, since they must make countless on-the-spot expert judgments each day in treating their patients. *See Doe v. McMillan*, *supra*, 412 U.S. at 320; *Smith v. Losee*, 485 F.2d 334, 342 (10th Cir. 1973)(en banc).

This good faith defense is particularly appropriate where, as here, fulfillment of defendant's duty is seriously hampered by thoroughly inadequate resources. All that can reasonably be asked in these circumstances is that the official make a good faith effort with the limited resources available. For example, in *Schmidt v. Wingo*, 499 F.2d 70 (6th Cir. 1974), *affirming* 368 F.Supp. 727 (W.D.Ky. 1973), plaintiff sought damages from the defendant prison warden, alleging that plaintiff's decedent, a prison inmate, died as a result of inadequate medical care furnished at the prison hospital. The court in *Schmidt* recognized that it would be both illogical and unjust "to place liability upon the Warden of a

penitentiary for the failure to furnish [adequate] equipment and personnel, where the budget for personnel and equipment are fixed by his superiors, the Department of Corrections and by the General Assembly of the State of Kentucky." 368 F.Supp. at 731; *see* 499 F.2d at 74.

Petitioner requests this Court to view this issue as it relates to state employed psychiatrists. Proper application of the good faith defense doctrine should immunize Petitioner from personal liability where, as in this case, if the evidence demonstrates overwhelmingly that he used his best efforts to treat Mr. Donaldson, who was, at best, a recalcitrant, uncooperative patient. Petitioner would caution the court that affirmance of the actions of the Court of Appeals would operate to elevate to constitutional demensions the myriad of day-to-day medical decisions that must be made by state employed psychiatrists. The picture of physicians afraid of liability for the act of prescribing a drug, altering a treatment plan, or acting on requests for privileges is not an attractive one.

Consonant with the above discussion of immunity, Petitioner believes that the evidence does not support the jury verdict in this case. The District Court should have granted the Motion for Directed Verdict made during trial. (A 140). Failing that, the District Court should have granted Petitioner's Motion for Judgment Notwithstanding the Verdict. Although this argument was not considered in depth in the Court of

Appeals, Petitioner believes that this Court may consider all aspects of the record and declare that the refusals of the District Court and the Court of Appeals to find in favor of Petitioner amounted to "plain error" reviewable in the absence of any objection by the parties.[19]

Conclusion

The theory of a constitutional right to treatment for civilly committed mental patients is a novel innovation in the law, but is one with which Petitioner agrees in spirit. However, the constitutional right to treatment as announced, without guidelines for enforcement, by the Court of Appeals for the Fifth Circuit cannot be allowed to exist as such. It is a fine statement of a moral right, but absent essential guidelines for recognition, definition, enforcement and implementation, it does not rise to the status of a legal right. It is among that class of obligations spoken to by Justice Holmes: "Legal obligations that exist but cannot be enforced are ghosts that are seen in the law but that are elusive to the grasp."[20]

---

19 See, e.g., *Silber v. United States*, 370 U.S. 717, 718 (1962); *United States v. Atkinson*, 297 U.S. 157, 160 (1936).

20 *The Western Maid*, 257 U.S. 419, 433 (1922).

Accordingly, Petitioner requests this Court to view the issues of this case in a broad light. The legal issue of whether there exists a constitutional right to a certain level of treatment aside, Petitioner asks this Court to view the record independent of the jury verdict and findings of the Court of Appeals. Petitioner firmly believes that such an investigation will reveal that the evidence did not support the verdict rendered below.

Finally, Petitioner requests the Court to consider the propriety of the retroactive application of a recently established constitutional right, such as occurrred in this case.

For reasons set forth above, it is respectfully submitted that the judgment of the Court of Appeals should be reversed.

Respectfully submitted,

ROBERT L. SHEVIN
ATTORNEY GENERAL

DANIEL S. DEARING
Special Assistant Attorney
General

RAYMOND W. GEAREY
Assistant Attorney General

Department of Legal Affairs
The Capitol
Tallahassee, Florida 32304

Attorneys for Petitioner.

REPLY BRIEF

APPENDIX

Chapter 394, Florida Statutes

PART I

FLORIDA MENTAL HEALTH ACT

394.451 Short title.
394.453 Legislative intent.
394.455 Definitions.
394.457 Operation and administration.
394.459 Rights of patients.
394.460 Rights of physicians.
394.461 Facilities; transfer of patients.
394.463 Admission for emergency or evaluation.
394.465 Voluntary admissions.
394.467 Involuntary hospitalization.
394.469 Discharge of patients.
394.471 Validity of prior hospitalization orders.
394.473 Attorneys' and physicians' fees.
394.475 Acceptance, examination, and involuntary hospitalization of Florida residents from out-of-state mental health authorities.
394.477 Residence requirements.
394.478 Autopsy of deceased patient.

394.451 Short title.—This part I of chapter 394 shall be known as "The Florida Mental Health Act" or "The Baker Act."

History.—§1, ch. 71-131.

394.453 Legislative intent.—It is the intent of the legislature to authorize and direct the department of health and rehabilitative services to evaluate, research, plan, and recommend to the governor and the legislature programs designed to reduce the occurrence, severity, duration, and disabling aspects of mental, emotional,

BEST COPY AVAILABLE

and behavioral disorders. The department of health and rehabilitative services is directed to implement and administer programs through the division of mental health as authorized and approved by the legislature, based on the department's annual program budget. It is the further intent of the legislature that programs of the department shall coordinate the development, maintenance, and improvement of receiving and community treatment facilities within the programs of the district mental health boards as authorized by the community mental health act, part IV of this chapter. Treatment programs shall include, but not be limited to, comprehensive health, social, educational, and rehabilitative services to persons requiring intensive short term and continued treatment in order to encourage them to assume responsibility for their treatment and recovery. It is intended that patients shall be provided with emergency service and temporary detention for evaluation when required; that patients be admitted to treatment facilities on a voluntary basis when extended or continuing care is needed and unavailable in the community; that involuntary hospitalization be provided only when expert evaluation determines that it is necessary; and that individual dignity and human rights be guaranteed to all persons admitted to mental health facilities.

History.—s2, ch. 71-131.

394.455 Definitions.—As used in this part, unless the context clearly requires otherwise:

(1) "Hospital" means a public or private hospital or institution or part thereof licensed by the division of health of the department of health and rehabilitative services and equipped to provide inpatient care and treatment facilities, or any hospital under the supervision of the department.

(2) "Physician" means an individual licensed or authorized to practice medicine or osteopathy under the laws of Florida.

(3) "Mentally ill" means having a mental, emotional, or behavioral disorder which substantially impairs the person's mental health.

(4) "Department" means the department of health and rehabilitative services.

BEST COPY AVAILABLE

(5) "Division" means the division of mental health of the department of health and rehabilitative services.

(6) "Secretary" means the secretary of the department of health and rehabilitative services.

(7) "Director" means the director of the division of mental health of the department of health and rehabilitative services.

(8) "Mental health board" means the board within a board district established in accordance with the provisions of the community mental health act, part IV of this chapter, for the purposes of administering the community mental health program.

(9) "Board district" means that area over which a single mental health board has jurisdiction for administering mental health programs as provided by the community mental health act, part IV of this chapter, and may consist of one or more services districts.

(10) "Facility" means any state-owned or state-operated hospital or state-aided community facility designated by the department to be utilized for the evaluation, diagnosis, care, treatment, training, or hospitalization of persons who are mentally ill, and any other hospital within the state approved and designated for such purpose by the department.

(11) "Community facility" means a facility which receives funds from the state under the community mental health act, part IV of this chapter.

(12) "Receiving facility" means a facility designated by the department to receive patients under emergency conditions or for psychiatric evaluation and to provide short-term treatment, and also means a private facility when rendering services to a private patient pursuant to the provisions of this act.

(13) "Treatment facility" means a state-owned, state-operated, or state-supported hospital, center, or clinic designated by the department for the treatment and hospitalization of persons who are mentally ill, including facilities of the United States government, and also

means a private facility when rendering services to a private patient pursuant to the provisions of this act. Patients treated in facilities of the United States government shall be solely those whose care is the responsibility of the Veterans' Administration.

(14) "Private facility" means any hospital or facility operated by a nonprofit corporation or association or a proprietary hospital approved by the department.

(15) "Patient" means any mentally ill person who seeks hospitalization under this part, or any person for whom such hospitalization is sought.

(16) "Administrator" means the chief administrative officer of a receiving or treatment facility or his designee.

(17) "Staff member" means an employee of a receiving or treatment facility who has been designated as a staff member by the department.

(18) "Law enforcement officer" means any city police officer, officer of the state highway patrol, sheriff, or deputy sheriff.

(19) "Guardian" means a natural guardian of a minor or a legal guardian appointed by a court to maintain custody and control of the person or of the property of an incompetent.

(20) "Representative" means a person appointed to receive notice of proceedings for and during hospitalization and to take actions for and on behalf of the patient.

(21) "Court," unless otherwise specified, means the circuit court.

(22) "Judge," unless otherwise specified, means the judge of the circuit court or the judge designated to act under this act by the chief judge of a circuit.

(23) "Clinical record" means all parts of the record required to be maintained and includes all medical records, progress notes, charts, admission and discharge data, and all other information recorded by a facility which pertains to the patient's hospitalization and treatment.

History.—§3, ch. 71-131; §1, ch. 72-356; §1, ch. 73-131; §25, ch. 73-334.

394.457 Operation and administration.—

(1) ADMINISTRATION.—The department, by and through the division of mental health, is designated the mental health authority of Florida. The department shall exercise executive and administrative supervision over all division facilities, programs, and services.

(2) RESPONSIBILITIES OF THE DEPARTMENT.—The department is responsible, through the division, for the planning, evaluation and coordination of a complete and comprehensive statewide program of mental health including community services, receiving and treatment facilities, child services, research, and training. The department is also responsible, through the division, for the implementation of programs and coordination of efforts with other departments and divisions of the state government, county and municipal governments, and private agencies concerned with and providing mental health services. It is responsible for establishing standards, providing technical assistance, and exercising supervision of mental health programs of state-supported community facilities and other facilities for the mentally ill. It shall stimulate research by public and private agencies, institutions of higher learning, and hospitals in the interest of the elimination and amelioration of mental illness.

(3) POWER TO CONTRACT.—The department, through the division, may contract to provide, and be provided with, services and facilities in order to carry out its responsibilities under this part with the following agencies: district mental health boards; public and private hospitals; clinics; laboratories; departments, divisions and other units of state government; the state colleges and universities; the community colleges; private colleges and universities; counties, municipalities, and any other governmental unit, including facilities of the United States government; and any other public or private entity which provides or needs facilities or services. Services contracted for by the division may be reimbursed by the state at a rate up to 100 percent. The department shall make periodic audits and inspections to assure that the contracted services are provided and meet the standards of the department.

(4) APPLICATION FOR AND ACCEPTANCE OF GIFTS AND GRANTS.—The department, through the division, may apply for, and accept any funds, grants, gifts, or services made available to it by any agency or department of the federal government or any other public or private agency or individual in aid of mental health programs. All such moneys shall be deposited in the state treasury and shall be disbursed as provided by law.

(5) RULES AND REGULATIONS; PERSONNEL.—

(a) The department shall adopt rules and regulations necessary for administration of this part in accordance with the administrative procedure act, chapter 120.

(b) The director of the division of mental health shall be qualified for the position by graduation from an accredited school of medicine and be licensed to practice medicine in at least one state and shall have sufficient training and experience in the field of psychiatry to meet the requirements for examination by the American Board of Psychiatry and Neurology, Inc., or be a qualified licensed practicing physician.

(c) The department shall, by regulation, establish standards of education and experience for professional and technical personnel employed in mental health programs.

(6) HEARING EXAMINERS.—

(a) One or more hearing examiners shall be appointed by the secretary to hold hearings for continued hospitalization. Such hearing examiners shall be members of The Florida Bar and shall be compensated by the department.

(b) In the conduct of hearings the hearing examiner shall have the authority to:

1. Administer oaths and affirmations;

2. Sign and issue subpoenas for the appearance of witnesses and production of documents required for the conduct of the hearing;

3. Rule on evidence;

4. Provide for the taking of testimony by deposition.

(c) If a subpoena issued by the hearing examiner is disobeyed, the hearing examiner may apply to the circuit court of the county in which the hearing is held for an order requiring compliance.

(d) An order of the hearing examiner shall be reviewable by the circuit court of the county in which the hearing is held.

(7) PAYMENT FOR CARE OF PATIENTS.—Fees for patients in treatment facilities shall be based on a fee schedule prepared and published by the department. Fees shall be collected by the division and be based on cost of care and ability to pay. An unpaid fee shall constitute a lien on the nonexempt property of the patient; however, payment of charges shall not be a prerequisite to treatment. Legal action for recovery of unpaid fees shall be brought by the department or by the department of legal affairs for the department.

(8) DESIGNATION OF TREATMENT FACILITIES.—Florida State Hospital located at Chattahoochee, Gadsden County; G. Pierce Wood Memorial Hospital located at Arcadia, DeSoto County; South Florida State Hospital located at Hollywood, Broward County; and Northeast Florida State Hospital located at Macclenny, Baker County; and such other facilities as may be established by law or designated by the department, including facilities of the United States government, if such designation is agreed to by the appropriate governing body or authority, are designated as treatment facilities.

(9) DESIGNATION OF APPROVED PRIVATE PSYCHIATRIC FACILITIES.—Private psychiatric facilities may be approved by the department to provide emergency admission, court-ordered evaluation, and treatment on an involuntary basis. Such facilities are authorized to act in the same capacity as receiving and treatment facilities and are subject to all the provisions of this part, except that patients shall have the right to a hearing for continued involuntary hospitalization every sixty days according to established hearing procedures set forth herein.

History.—§1, ch. 57-317; §1, ch. 59-222; §1, ch. 65-13; §4, ch. 65-22; §1, ch. 65-145; §1, ch. 67-334; §§11, 19, 31, 35, ch. 69-106; §4, ch. 71-131; §70, ch. 72-221; §2, ch. 72-396; §2, ch. 73-133; §25, ch. 75-191.

Note.—Formerly §§65.013; §402.10.

394.459 Rights of patients.—

(1) RIGHT TO INDIVIDUAL DIGNITY.—The policy of the state is that the individual dignity of the patient shall be respected at all times and upon all occasions, including any occasion when the patient is taken into custody, detained, or transported. Procedures, facilities, including jails, vehicles, and restraining devices utilized for criminals or those accused of crime shall not be used in connection with the noncriminal mentally ill except for the protection of the patient or others. If, in an emergency, a mentally ill person is placed in a jail, such a facility may be used only as long as the emergency exists and in no case longer than five days. Treatment shall be provided to the patient by his physician or the receiving facility staff. No person who is receiving treatment for mental illness in a hospital shall be deprived of any constitutional rights. However, if such a person is adjudicated incompetent pursuant to the provisions of this part, his rights may be limited to the same extent the rights of any incompetent person are limited by general law.

(2) RIGHT TO TREATMENT.—The policy of the state is that the department shall not deny treatment for mental illness to any person, and that no services shall be delayed at a receiving or treatment facility because of inability to pay.

(3) RIGHT TO INFORMED PATIENT CONSENT.—

(a) All patients entering a facility shall be asked to sign an "authorization for psychiatric treatment" form.

(b) In addition to the provisions of paragraph (a), in the case of surgical procedures requiring the use of a general anesthetic or electroconvulsive treatment, and prior to performing the procedure, written permission shall be obtained from the patient, if he is legally competent, from the parent or guardian of a minor patient, or from the guardian of an incompetent patient. The facility administrator or his designated representative may, with the concurrence of the patient's attending physician, authorize emergency surgical treatment if such treatment is deemed lifesaving and permission of the patient and his guardian or representative cannot be obtained.

(4) QUALITY OF TREATMENT.—

(a) Each patient in a facility shall receive treatment suited to his needs, which shall be administered skillfully, safely, and humanely with full respect for his dignity and personal integrity. Each patient shall receive such medical, vocational, social, educational, and rehabilitative services as his condition requires to bring about an early return to his community. In order to achieve this goal the department is directed to coordinate the programs of the division with all other divisions of the department.

(b) If a patient is able to secure the services of a private physician, he shall be allowed to see his physician at any reasonable time. In addition, any patient's attending physician may utilize the services of a consulting physician for the purpose of aiding in evaluation, diagnosis, and treatment. Such consultant may be reimbursed in a manner to be determined by the department within available funds, for services related to this act. The department shall establish regulations designed to facilitate examination and treatment by private physicians on a consulting basis.

(5) COMMUNICATION AND VISITS.—

(a) Each patient in a facility has the right to communicate freely and privately with persons outside the facility unless it is determined that such communication is likely to be harmful to the patient or others.

(b) Each patient shall be allowed to receive, send, and mail sealed, unopened correspondence, and no patient's incoming or outgoing correspondence shall be opened, delayed, held, or censored by the facility unless there is reason to believe that it contains items or substances which may be harmful to the patient or others, in which case the administrator may direct reasonable examination of such mail and may regulate the disposition of such items or substances.

(c) If a patient's right to communicate is restricted by the administrator, written notice of such restriction shall be served on the patient and his guardian or representatives, and such restriction shall be recorded on the patient's clinical record with the reasons therefor. The restriction of a patient's right to communicate shall be reviewed at least every ninety days.

(d) The department shall establish reasonable regulations governing visitors, visiting

hours, and the use of telephones by patients.

(6) CARE AND CUSTODY OF PERSONAL EFFECTS OF PATIENTS.—A patient's right to his clothing and personal effects shall be respected. The administrator may take temporary custody of such effects when required for medical and safety reasons. Custody of such personal effects shall be recorded in the patient's clinical record.

(7) VOTING IN PUBLIC ELECTIONS.—A patient in a facility who is eligible to vote according to the laws of the state has the right to vote in the primary and general elections. The department shall establish rules and regulations to enable patients to obtain voter registration forms, applications for absentee ballots, and absentee ballots.

(8) EDUCATION OF CHILDREN.—The department shall provide education and training appropriate to the needs of all children in treatment facilities.

(9) CLINICAL RECORD; CONFIDENTIALITY.—A clinical record for each patient shall be maintained. The record shall include data pertaining to admission and such other information as may be required under regulations of the department. Unless waived by the patient or his guardian or attorney, the privileged and confidential status of the clinical record shall not be lost by either authorized or unauthorized disclosure to any person, organization, or agency. The clinical record shall not be a public record and no part of it shall be released, except:

(a) The record may be released to physicians, attorneys, and government agencies as designated by the patient, his guardian or his attorney.

(b) The record shall be produced in response to a subpoena or released to persons authorized by order of court, excluding matters privileged by other provisions of law.

(c) The record or any part thereof may be disclosed to a qualified researcher, a staff member of the facility, or an employee of the department when the administrator of the facility or secretary of the department deems it necessary for treatment of the patient, maintenance of adequate records, compilation of treatment data, or evaluation of programs.

(d) Information from the clinical records may be used for statistical and research purposes if the information is abstracted in such a way as to protect the identity of individuals.

(10) HABEAS CORPUS.—

(a) At any time, and without notice, a person detained by a facility, or a relative, friend, guardian, representative, or attorney on behalf of such person, may petition for a writ of habeas corpus to question the cause and legality of such detention and request that the circuit court issue a writ for release. Each patient admitted to a facility for involuntary hospitalization shall receive a written notice of the right to petition for a writ of habeas corpus.

(b) A patient or his guardian or representatives may file a petition in the circuit court in the county where the patient is hospitalized alleging that the patient is being unjustly denied a right or privilege granted herein or that a procedure authorized herein is being abused. Upon the filing of such a petition, the circuit court shall have the authority to conduct a judicial inquiry and to issue any appropriate order to correct an abuse of the provisions of this part.

(11) TRANSPORTATION.—If neither the patient nor any person legally obligated or responsible for the patient is able to pay for the expense of transporting the patient to a treatment facility, the governing board of the county from which the patient is hospitalized shall arrange for such required transportation. The department shall promulgate rules and regulations to insure safe and dignified transportation for all patients.

(12) DESIGNATION OF REPRESENTATIVES; NOTICE OF ADMISSION.—

(a) At the time a patient is admitted to a facility, the names and addresses of two representatives or one guardian shall be entered in the patient's clinical record.

1. A treatment facility shall give written notice of the patient's admission to his guardian or representatives.

2. A receiving facility shall give notice of admission to the patient's guardian or representatives by telephone or in person within twenty-four hours.

(b) If the patient has no guardian, he may designate one representative; the second representative, or both in the absence of designation of one representative by the patient, shall be selected by the facility. The first representative selected by the facility shall be made from the following in the order of listing:

1. The patient's spouse;
2. An adult child;
3. Parent;
4. Adult next of kin;
5. Adult friend; or
6. The division of family services.

The second representative selected by the facility shall be without regard to the order of listing. If the facility can locate only one person from the categories listed above, it shall only be required to select one representative.

(c) Unless otherwise provided, notice to the patient's guardian or representatives shall be served by registered or certified mail, and the date on which such notice was mailed shall be entered on the patient's clinical record.

(13) LIABILITY FOR VIOLATIONS.—Any person who violates or abuses any rights or privileges of patients provided by this act shall be liable for damages as determined by law. Any person who acts in good faith in compliance with the provisions of this part shall be immune from civil or criminal liability for his actions in connection with the admission, diagnosis, treatment, or discharge of a patient to or from a facility. However, this section shall not relieve any person from liability if such person is guilty of negligence.

History.—§5, ch. 71-131; §1, ch. 73-133; §25, ch. 73-331.

394.460 Rights of physicians.—No physician shall be required to accept patients for treatment of mental, emotional, or behavioral disorders. Such participation shall be voluntary.

History.—§4, ch. 73-133.

BEST COPY AVAILABLE

394.461 Facilities; transfers of patients.—

(1) RECEIVING FACILITY.—The department, through the division, may designate any community facility as a receiving facility for emergency, short term treatment and evaluation. The governing board of any county is authorized to contract with the department or with the mental health board of a board district, with the approval of the department, to set aside an area of any facility of the department to function, and be designated, as the receiving facility. Any other facility within the state, including a federal facility, may be so designated by the department at the request of and with the consent of the governing officers of the facility.

(2) TREATMENT FACILITY.—Any state-owned, state-operated, or state-supported facility may be designated by the department as a treatment facility. Any other facility, including a federal facility, may be so designated by the department at the request of, or with the consent of, its governing officers.

(3) TRANSFERS OF PATIENTS.—

(a) Any patient who has been admitted to a treatment or receiving facility on a voluntary basis and is able to pay for treatment in a private facility may apply to the department for transfer at his expense to such private facility. A patient may apply to the department for transfer from a private facility to a public facility. An involuntary patient may be transferred at the discretion of the department or upon application by the patient or the guardian of said patient.

(b) When the medical needs of the patient or efficient utilization of the facilities of the department require, a patient may be transferred from one facility of the department to another or, with the consent of the patient and his guardian or representatives, to a facility in another state.

(c) When any patient is to be transferred, notice shall be given to his guardian or representatives prior to the transfer.

History.—§6, ch. 71-131; §3, ch. 72-396; §5, ch. 73-133.

394.463 Admission for emergency or evaluation.—

(1) EMERGENCY ADMISSION.—

(a) *Criteria.*—A person may be admitted to a receiving facility on emergency conditions if there is reason to believe that he is mentally ill and because of his illness is:

1. Likely to injure himself or others if allowed to remain at liberty, or

2. In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf, and an ex parte order is obtained authorizing the admission.

(b) *Initiation of proceeding.*—An emergency admission may be initiated as follows:

1. A judge may enter an ex parte order stating that a person appears to meet the criteria for emergency admission, giving the findings on which that conclusion is based and directing that a law enforcement officer take the person into custody and deliver him to the nearest receiving facility for emergency examination and treatment. The order of the court shall be made a part of the patient's clinical record; or

2. A law enforcement officer may take a person who appears to meet the criteria for emergency admission into custody and deliver him to the nearest receiving facility for emergency examination and treatment. The officer shall execute a written report detailing the circumstances under which the person was taken into custody, and the report shall be made a part of the patient's clinical record; or

3. A physician may execute a certificate that he has examined a person within the preceding forty-eight hours and finds that the person appears to meet the criteria for emergency admission, stating the observations upon which that conclusion is based. The physician's certificate shall authorize a law enforcement officer to take the person into custody and deliver him to the nearest available receiving facility for emergency examination and treatment. The law enforcement officer shall execute a written report detailing the circumstances under which the person was taken into custody. The report and physician's certificate shall be made a part of the patient's clinical record.

(c) *Emergency examination.*—A patient who is admitted for an emergency examination and treatment by a receiving facility shall be examined by a physician without unnecessary delay, and may be given such treatment as is indicated by good medical practice.

(d) *Release of patient.*—At any time the examining physician concludes that the patient need not be hospitalized or that further evaluation is not necessary, the patient shall be discharged immediately unless the patient is under criminal charges, in which case he shall be returned to the custody of a law enforcement officer. The patient must be released within forty-eight hours of his admission except when the examining physician concludes that there is reason to believe that the patient may require evaluation or treatment, in which case, unless the patient voluntarily agrees to evaluation, treatment, or hospitalization, a proceeding for court-ordered evaluation or involuntary hospitalization shall be initiated.

(2) COURT-ORDERED EVALUATION.—

(a) *Criteria.*—A person may be admitted to, or retained in, a receiving facility for evaluation if there is reason to believe that he is mentally ill and because of his illness is:

1. Likely to injure himself or others if allowed to remain at liberty, or

2. In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf.

(b) *Initiation of proceeding.*—A court-ordered evaluation may be initiated as follows:

1. Any person may file with the court a petition, executed under oath and supported by affidavits of two additional persons, requesting an evaluation of a person located in the county who is alleged to meet the criteria for a court-ordered evaluation; or

2. Any person may file with the court a petition executed under oath alleging that a person in the county meets the criteria for a court-ordered evaluation. The petition must be accompanied by the certificate of a physician stating that he has examined the patient within the preceding five days and has found that the patient may be mentally ill and in need of hospitalization and that a full evaluation is necessary.

(c) *Notice; hearing on petition.*—The judge shall set a hearing on the petition and shall serve notice of the time and place of such hearing on the patient, his guardian, if one has previously been appointed, and the person, if any, having custody and control of the patient. In the absence of a guardian, two other representatives for the service of the notice shall be designated by the court, one of whom, other than the person who filed the petition, shall be selected in the following order:

1. The patient's spouse;
2. An adult child;
3. Parent;
4. Adult next of kin;
5. Adult friend; or
6. The division of family services.

The second representative shall be selected from the above list without regard to the order of listing. The court shall make such efforts, as in its discretion it determines reasonable in view of the emergency, to contact the persons listed above in the order listed. The court shall notify any other person, including any persons whose names appear in the patient's court file, that the judge believes has a concern for the patient's welfare. The hearing shall be set within five days of the date of mailing the notice with a copy of the petition attached. The court shall grant a continuance upon application by the patient, his guardian, or a representative if such continuance is found necessary to permit preparation for the hearing. The hearing may be waived in writing by the patient. The patient and his guardian or representatives shall be informed of the right to counsel by the judge and, if the patient cannot afford an attorney to represent him at the hearing, the judge shall appoint one.

(d) *Order for evaluation.*—After a hearing or, if the hearing is waived, after a review of all evidence, if the judge is satisfied that immediate evaluation is necessary, he shall issue an

order to any law enforcement officer to deliver the patient to a receiving facility for evaluation. If the judge is satisfied that evaluation is necessary, but that the patient need not be hospitalized immediately for his own safety or that of others, he may order the patient to appear at a designated receiving facility at a specified time within three days. If the patient fails to appear at the specified time, the order of the court, countersigned by the administrator of the facility to show that the person did not appear as ordered, shall authorize and direct any law enforcement officer to take the person into custody and deliver him to the specified receiving facility.

(e) *Evaluation by a receiving facility.*—A patient who is admitted to a receiving facility may be detained for a period not to exceed five days. The staff members of all receiving facilities shall encourage patients to apply for voluntary hospitalization if hospitalization appears necessary. Within the five day evaluating period one of the following actions shall be taken:

1. The patient shall be released;
2. The patient shall be released for outpatient treatment by a community facility;
3. The patient shall agree to hospitalization as a voluntary patient; or
4. Proceedings for involuntary hospitalization shall be initiated.

Treatment shall be made available when determined by a receiving facility physician to be necessary.

(3) DISCHARGE OF PATIENT.—At any time the patient is found not to require hospitalization for emergency treatment or evaluation, the receiving facility shall discharge the patient unless the patient is under criminal charges, in which case he shall be returned to the custody of a law enforcement officer. Notice of the discharge shall be given to the patient's guardian or representatives, to any physician who executed a certificate admitting the patient to the receiving facility, and to any court which ordered the patient's evaluation.

History.—§7, ch. 71-131, §6, ch. 73-191.

394.465 Voluntary admissions.—

(1) AUTHORITY TO RECEIVE PATIENTS.—

(a) A facility may receive for observation, diagnosis, or treatment any individual eighteen years of age or older making application for admission or any individual between the ages of twelve through seventeen for whom such application is made by his parent or guardian. If found to show evidence of mental illness and to be suitable for treatment, such person may be admitted to the facility.

(b) A facility may admit for evaluation, diagnosis, or treatment any individual twelve years of age or older who makes application therefor. If such individual is under eighteen years of age, his parent or guardian may apply for his discharge, and the administrator shall release the patient within five days of such application for discharge.

(2) RIGHT OF VOLUNTARY PATIENTS TO DISCHARGE.—

(a) A facility shall discharge a voluntary patient who has sufficiently improved so that hospitalization is no longer desirable. A patient may also be discharged to the care of a community facility. A voluntary patient or his guardian, representative, or attorney may request discharge in writing at any time following admission to the facility. This request may be submitted to a member of the staff of the facility for transmittal to the administrator. If the patient, or another on his behalf, makes an oral request for release to a staff member, such request shall be immediately entered in the patient's clinical record, and the patient must within three days be given counseling and assistance in preparing a written request. If a written request is submitted to a staff member, it shall be delivered to the administrator within twenty-four hours. Within five days of delivery of a written request for release to the administrator, the patient must be discharged from the facility or a plan instituted for a discharge of the patient.

Such plan shall be approved by the patient. If discharge would be unsafe to the patient or others, proceedings for involuntary hospitalization must be initiated within three days of delivery of the written request. If the patient was admitted on his own application and the request for discharge is made by a person other than the patient, the discharge may be conditioned upon the agreement of the patient. If the patient is under the age of eighteen, his parent or guardian may act for him.

(b) If the administrator, upon the advice of the patient's attending physician, determines that the patient needs to be transferred to a long-term treatment facility and the patient refuses to go as a voluntary patient, the administrator shall be authorized to file a petition for involuntary hospitalization.

(3) NOTICE OF RIGHT TO RELEASE.—At the time of his admission and each six months thereafter, a voluntary patient and his guardian or representatives shall be notified in writing of his right to apply for a discharge.

(4) TRANSFER TO VOLUNTARY STATUS.—Staff members of all treatment facilities shall encourage an involuntary patient to transfer to voluntary status unless the patient is under criminal charge, or unless the patient is unable to understand the nature of voluntary hospitalization or unless voluntary hospitalization would be harmful to the patient, in which case a finding to this effect shall be entered in the patient's clinical record. Any involuntary patient who applies shall be transferred to voluntary status immediately, unless such transfer would not be in the best interest of the patient, in which case such finding shall be entered in the patient's clinical record and shall be subject to review every ninety days. When transfer to voluntary status occurs, notice shall

be given to the patient and his guardian or representatives and, if the patient is hospitalized under an order of court, to the court which entered such order.

(5) TRANSFER TO INVOLUNTARY STATUS.—A patient who has agreed to be hospitalized as a voluntary patient and, upon arrival at the treatment facility, refuses to remain as a voluntary patient may be detained by the treatment facility for a period not to exceed five days while the administrator of the treatment facility initiates procedures for involuntary hospitalization.

History.—§8, ch. 71-131; §7, ch. 73-133; §109, ch. 73-333.

394.467 Involuntary hospitalization.—

(1) CRITERIA.—A person may be involuntarily hospitalized if he is mentally ill and because of his illness is:

(a) Likely to injure himself or others if allowed to remain at liberty, or

(b) In need of care or treatment and lacks sufficient capacity to make a responsible application on his own behalf.

(2) ADMISSION TO A TREATMENT FACILITY.—A patient may be hospitalized in a treatment facility, after notice and hearing, upon recommendation of the administrator of a receiving facility where the patient has been admitted for examination or evaluation. When a patient is not an inpatient in a receiving facility, the administrator of a designated receiving facility may make a recommendation for involuntary hospitalization of a patient who has been given an examination, evaluation, or treatment by staff of the receiving facility or a private physician. The hearing may be waived in writing by the patient. The recommendation must be supported by the opinions of two physicians who have personally examined the patient within the preceding five days that the criteria for involuntary hospitalization are met. Such recommendation shall be entered on a hospitalization certificate, which certificate shall authorize the receiving facility to retain the patient pending

transfer to a treatment facility or completion of a hearing. The certificate shall be filed with the court in the county where the patient is located and shall serve as a petition for a hearing regarding involuntary hospitalization. *[A copy of] the certificate shall also be filed with the division, and copies shall be served on the patient and his guardian or representatives, accompanied by:

(a) A written notice, in plain and simple language, that the patient or his guardian or representative may apply at any time for a hearing on the issue of the patient's need for hospitalization if he has previously waived such a hearing.

(b) A petition for such hearing, which requires only the signature of the patient or his guardian or representative for completion.

(c) A written notice that the petition may be filed with a court in the county in which the patient is hospitalized at the time the certificate is executed and the name and address of the judge of such court.

(d) A written notice that the patient or his guardian or representative may apply immediately to the court to have an attorney appointed if the patient cannot afford one.

The petition may be filed in the county in which the patient is hospitalized at any time within six months of the date of the certificate. The hearing shall be held in the same county, and one of the patient's physicians at the hospital shall appear as a witness at the hearing. If the hearing is waived, the court shall order the patient to be transferred to a treatment facility or, if he is at a treatment facility, that he be retained there. However, the patient can be immediately transferred to the treatment facility by waiving his hearing without awaiting the court order. The hospitalization certificate shall serve as authorization for the patient to be transferred to a treatment facility and as authorization for the treatment facility to admit the patient. The treatment facility may retain a patient for a period not to exceed six months from the date of admission.

BEST COPY AVAILABLE

If continued hospitalization is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization.

(3) PROCEDURE FOR HEARING ON HOSPITALIZATION.—

(a) If the patient does not waive a hearing or if the patient, his guardian, or a representative files a petition for a hearing after having waived it, the judge shall serve notice on the administrator of the facility in which the patient is hospitalized, and may serve notice on the state attorney of the judicial circuit of the county in which the patient is hospitalized, who shall represent the state. The court shall hold the hearing within five days unless a continuance is granted. The patient, his guardian or representative, or the administrator may apply for a change of venue for the convenience of parties or witnesses or because of the condition of the patient. Venue may be ordered changed within the discretion of the court. The patient and his guardian or representative shall be informed of the right to counsel by the court. If the patient cannot afford an attorney, the court shall appoint one. One of the physicians who executed the hospitalization certificate shall be a witness. If the court concludes that the patient meets the criteria for involuntary hospitalization, the judge shall order the patient to be transferred to a treatment facility, or, if he is at a treatment facility, that he be retained there, or to be treated at any other appropriate facility or service on an involuntary basis. The order shall adequately document the nature and extent of a patient's mental illness. The judge may adjudicate a person incompetent pursuant to the provisions of this act at the hearing on hospitalization. The treatment facility may accept and retain a patient admitted involuntarily for a period not to exceed six months whenever the patient

is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient. If further hospitalization is necessary at the end of that period, the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization.

(b) In the event a person is ordered into a treatment facility under the provisions of the Florida Rules of Criminal Procedure or chapter 801 or chapter 917, the order shall adequately document the nature and extent of a patient's mental illness. The treatment facility may accept and retain a patient so admitted for a period not to exceed six months whenever the patient is accompanied by a court order and adequate documentation of the patient's mental illness. Such documentation shall include a psychiatric evaluation and any psychological and social work evaluations of the patient and document the results of any criminal investigation on the patient. "[If] a patient is considered to be suffering from an emotional illness to the extent that he cannot participate in his own defense, such documentation should include details regarding the evaluation which led to that conclusion. If further hospitalization is necessary at the end of his authorized treatment period, the administrator shall apply to the hearing examiner for an order authorizing continued hospitalization.

(c) The court shall provide a court order, a psychiatric evaluation, and other adequate documentation of each patient's mental illness to the administrator of a treatment facility whenever a patient is ordered for involuntary hospitalization, whether by civil or criminal court. The administrator of a treatment facility may refuse admission to any patient directed to its facilities on an involuntary basis, whether by civil or by criminal court order, who is not accompanied at the same time by adequate orders and documentation.

(4) PROCEDURE FOR CONTINUED HOSPITALIZATION; HEARING EXAMINER.—

(a) If continued hospitalization of an involuntary patient is necessary, the administrator shall, prior to the expiration of the period during which the treatment facility is authorized to retain the patient, request an order authorizing continued hospitalization. This request shall be accompanied by a statement from the patient's physician justifying the request and a brief summary of the patient's treatment during the time he was hospitalized. In addition, the administrator shall submit an individualized plan for the patient for whom it is requesting continued hospitalization. Notification of this request for retention shall be mailed to the patient and his guardian or representative along with a completed petition, requiring only a signature, for a hearing regarding the continued hospitalization and a waiver of hearing form. The waiver of hearing form shall state that the patient is entitled to a hearing under the law; that he is entitled to be represented by an attorney at the hearing and, if he cannot afford an attorney, that one will be appointed; and that, if it is shown at the hearing that the patient does not meet the criteria for involuntary hospitalization, he is entitled to be released. If the patient or his guardian or representative does not sign the petition, or if the patient does not sign a waiver within fifteen days, the hearing examiner shall notice a hearing with regard to the patient involved within ten days after the expiration of the aforesaid period.

(b) Any time continued hospitalization is requested, the hearing examiner may, on his own motion, notice a hearing.

(c) Any time continued hospitalization is requested by the administrator, the administrator may request a hearing, and the hearing examiner shall hold a hearing within fifteen days of such request.

(d) The administrator shall not transfer any patient to voluntary status when he has reasonable cause to believe that the patient is dangerous to himself or others. In any case in which the administrator has reasonable cause to believe that an involuntary patient is dangerous to himself or others, the administrator shall request continued hospitalization. In any case in which a request for continued hospitalization is necessary, but the administrator after reviewing the case believes there is not reasonable cause to believe that the patient meets the criteria for involuntary hospitalization at the time of application for transfer to voluntary status and the patient needs continued hospitalization, the patient shall be transferred to a voluntary status.

(e) If the patient or his guardian or representative returns the signed petition noted in paragraph (a), the hearing examiner shall set a time and place for a hearing to be held within ten days of the time he receives the petition. A continuance not to exceed five days may be granted at the discretion of the hearing examiner. The patient and his guardian or representative shall be informed of the right to counsel by the hearing examiner. In the event a patient cannot afford counsel in a hearing before a hearing examiner, the public defender in the county where the hearing is to be held shall act as attorney for the patient.

(f) If the patient waives his hearing or if at a hearing it is shown that the patient continues to meet the criteria for involuntary hospitalization, the hearing examiner shall sign the order for continued hospitalization. The treatment facility shall be authorized to retain the patient for a period not to exceed one year. The same procedure shall be repeated prior to the expiration of each additional one-year period the patient is retained.

**(g) If continued hospitalization is neces-

sary for an individual admitted while serving a criminal sentence, but whose sentence is about to expire, or for an individual hospitalized while a minor, but who is about to reach the age of twenty-one, the administrator shall petition the hearing examiner for an order authorizing continued hospitalization.

History.—§9, ch. 71-131; §8, ch. 73-133.
*Note.—Bracketed words inserted by the editors.
**Note.—Ch. 73-21, Laws of Florida, removed the disability of nonage for persons 18 years of age and older.
Cf.—§1.01(14) Definition of minor.
§744.07 Rights, privileges and obligations of persons 18 years of age or older.
§744.31 Petition for appointment of guardian for a person mentally or physically incompetent.

394.469 Discharge of patients.—

(1) POWER TO DISCHARGE.—At any time a patient is found no longer to meet the criteria for involuntary hospitalization, the administrator may:

(a) Discharge the patient, unless the patient is under a criminal charge, in which case he shall be transferred to the custody of the appropriate law enforcement officer;

(b) Transfer the patient to voluntary status on his own authority or at the patient's request, unless the patient is under criminal charge; or

(c) Place an improved patient, except a patient under a criminal charge, on convalescent status in the care of a community facility.

(2) NOTICE.—Notice of discharge or transfer of status shall be given to the patient, his guardian or representatives, and, if the patient's hospitalization was by order of a court, the court which entered such order.

(3) CONVALESCENT STATUS; REHOSPITALIZATION.—An improved patient may be placed on convalescent status for a period of up to one year in the care of a community facility when such action is in the best interest of the patient. Notice of the patient's placement on

convalescent status shall be given to the patient and his guardian or representatives, to the community facility, and, if the patient's hospitalization was by order of a court, to the court which entered the order. Placement on convalescent status shall include provisions for continuing responsibility by a community facility, including a plan for treatment on an out-patient basis. The administrator of the treatment facility from which the patient is given convalescent status may, at any time during the continuance of such convalescent status, rehospitalize the patient when the condition of the patient requires. An involuntary patient may be rehospitalized for the remainder of his authorized treatment period, and the treatment facility shall have up to one additional month during which to apply for continued hospitalization.

History.—§10, ch. 71-131; §9, ch. 73-133.
Cf.—§744.31 Petition for appointment of guardian for a person mentally or physically incompetent.

394.471 Validity of prior hospitalization orders.—No hospitalization of a mentally ill person, lawful before January 1, 1972, shall be deemed unlawful because of the enactment of this part. The department shall establish reasonable rules and regulations to require the administrator of each treatment facility to apply for an order authorizing continued hospitalization of any patient for whom hospitalization is necessary and who was initially hospitalized under an order of a court prior to July 1, 1972. Such prior orders, unless superseded by an order under this part, shall remain valid until July 1, 1973, after which all such orders shall be null and void and of no effect, and every patient retained shall become a voluntary patient unless previously placed on involuntary status pursuant to procedures under this part. Nothing in this part invalidates any order appointing a guardian or determining incompetency.

History.—§11, ch. 71-131.

BEST COPY AVAILABLE

394.473 Attorneys' and physicians' fees.—

(1) In case of indigency of any person for whom an attorney is appointed pursuant to the provisions of this part, the attorney shall be entitled to a reasonable fee to be determined by the circuit judge and paid from the general fund of the county from which the patient was hospitalized. In case of indigency of any such person, the court may appoint a public defender. The public defender shall receive no additional compensation other than that usually paid his office.

(2) When any person who previously retained an attorney is adjudged incompetent, the guardian of such incompetent shall be required to pay a reasonable fee to such attorney retained by the incompetent.

(3) In case of indigency of any person for whom the appearance of a physician is required in a court hearing pursuant to the provisions of this act, the physician, except a physician who is classified as a full-time employee of the state or who is receiving remuneration from the state for his time in attendance at the hearing, shall be entitled to a reasonable fee to be determined by the court and paid from the general fund of the county from which the patient was hospitalized.

History.—§13, ch. 71-131; §10, ch. 73-143; §25, ch. 73-334.

394.475 Acceptance, examination, and involuntary hospitalization of Florida residents from out-of-state mental health authorities.—

(1) Upon request of the state mental health authorities of another state, the division is authorized to accept as patients, for a period of not more than fifteen days, persons who are and have been bona fide residents of Florida for a period of not less than one year.

(2) Any person received pursuant to subsection (1) shall be examined by the staff of the state hospital where such patient has been accepted which examination shall be completed during the said fifteen day period.

(3) If upon examination such a person requires continued hospitalization, a petition for

a hearing regarding involuntary hospitalization shall be filed with the circuit judge of the county wherein the treatment facility receiving the patient is located or the county where the patient is a resident.

(4) During the pendency of the examination period herein provided for and the pendency of the involuntary hospitalization proceedings herein provided for, such person may continue to be detained by the treatment facility unless the circuit judge having jurisdiction enters his order to the contrary.

History.—§14, ch. 71-131; §25, ch. 73-334.

394.477 Residence requirements.— No person shall be hospitalized in a treatment facility under the provisions of this part who has not been a bona fide resident of the state continuously for one year immediately preceding his hospitalization. However, any person not a bona fide resident of the state may be hospitalized in a treatment facility pending transfer of said person back to the state of his residence. An indigent nonresident patient shall be transferred to the state of his residence at the expense of the county from which he was hospitalized. The treatment facility, with the approval of the department, shall retain any nonresident who cannot be transferred subject to the provisions of this part.

History.—§15, ch. 71-131.

394.478 Autopsy of deceased patient.—In every case where a person is committed to and received as a patient in the Florida state hospital, and shall die while a patient therein, it is lawful for the superintendent of the Florida state hospital, and he may hold and perform, or cause to be held and performed, an autopsy on such deceased patient, when such deceased patient leaves surviving him no relative or guardian, or when said superintendent shall be unable to communicate with or contact any relative or guardian of such deceased patient for the purpose of procuring consent to such autopsy, and when in the judgment and discretion of the superintendent of the Florida state hospital, such autopsy is in the interest of medical science necessary or desirable.

History.—§1, ch. 19367, 1939; CGL 1940 Supp. 365(311).
Note.—See former §394.19.

During oral argument, Mr. Justice Blackmun requested counsel for Petitioner to submit further information on earlier cases brought by Kenneth Donaldson, as noted at page 1 of the Petition for Writ of Certiorari, page 11 of the Petitioner's Brief, and page 14 of the Reply Brief. Estimates of the number of previous cases vary according to source. Dr. Morton Birnbaum has estimated the number at twelve[1] to eighteen[2]. A search of state files in the possession of various state agencies and courts reveals the following:

(1) Shortly after his commitment in 1957 Kenneth Donaldson wrote a letter to Chief Justice Glenn Terrell of the Florida Supreme Court which was treated as a Petition for Writ of Habeas Corpus and proceeded as *Donaldson v. Rogers*, No. 28-294. The Petition was denied on March 26, 1957. There was no reported opinion.

---

1 Birnbaum, *A Rationale for the Right*, 57 Geo.L.J. 752, 775 (1969).

2 Birnbaum, *The Right to Treatment: Some Comments on its Development*, which appeared in *Medical, Moral and Legal Issues in Mental Health Care*, ed. by Ayd, 1974.

(2) The second case began in 1960, again with a letter to the Florida Supreme Court which was treated as a Petition for Writ of Habeas Corpus. The case was styled *Donaldson v. Rogers*. After investigation a Return to the Writ was filed on August 2, 1960, by the Attorney General's Office. The Writ was denied on September 16, 1960, and reported at 123 So.2d 679. This denial was appealed to this Court in *In re Donaldson*, No. 244 Misc. The Petition for Writ of Certiorari was denied on October 10, 1960 and reported at 364 U.S. 808.

(3) Another attempt to seek review by this Court was made in 1962, to *Donaldson v. Florida*, No. 212 Misc., but was denied at 371 U.S. 806.

(4) In early 1963, Donaldson again sought habeas corpus relief in the Florida Supreme Court. The Petition was denied without opinion during July, 1963.

(5) Later in 1963, Donaldson filed a Petition for Writ of Habeas Corpus in Circuit Court in Gadsden County, Florida, on August 28, 1963. The matter was referred, by Circuit Judge Hugh Taylor to County Court with explanation that the Circuit Court had no jurisdiction but Donaldson could seek restoration of competency in the County Court which originally committed him. Donaldson apparently never pursued his remedy in Pinellas County Court. Donaldson appealed this case to the District Court of Appeals for the First District of Florida where the matter was considered

by a three-judge panel, but relief was denied without opinion on September 19, 1963.

(6) The next case appears in 1965. Donaldson filed an original petition for writ of habeas corpus in the Court of Appeals for the Fifth Circuit which was transferred to the Northern District of Florida on April 26, 1965. On April 30, 1965, Judge G. Harrold Carswell ordered the Florida Attorney General to file a response. After due investigation a Response was filed on May 20, 1965. On July 9, 1965, the District Court denied the Petition.

(7) Progress notes of May 1, 1967, in Donaldson's hospital records indicate a petition for writ of habeas corpus. (A 202(b)(i)). However, there are no records of this case.

(8) In 1968, Donaldson filed a Petition for Writ of Certiorari to the Court of Appeals for the Fifth Circuit. This may relate to the previous case. A check of Fifth Circuit records was unsuccessful. This Court denied the Petition, *Donaldson v. O'Connor*, No. 1045 Misc., 390 U.S. 971.

(9) In 1968, Donaldson sought habeas corpus relief in *Donaldson v. O'Connor* filed in Circuit Court in Leon County, Florida. This was transferred to Gadsden County and denied on January 8, 1969. Donaldson appealed to the District Court of Appeals for the First District of Florida. The appeal was dismissed as untimely on May 6, 1969. There was no reported opinion.

This same case was appealed to the Florida Supreme Court on May 12, 1969, where Donaldson was represented by Dr. Morton Birnbaum and the matter was briefed. The appeal was dismissed on November 20, 1969, and reported in *Donaldson v. O'Connor*, 234 So.2d 114.

A Petition for Writ of Certiorari was filed in this Court by Dr. Birnbaum on February 13, 1970, and on October 19, 1970, Certiorari was denied in *Donaldson v. O'Connor*, 400 U.S. 869 (1970).

As noted above, this information was obtained by a search of the records of the United States Court of Appeals for the Fifth Circuit, the United States District Court for the Northern District of Florida, the Florida Supreme Court, the District Court of Appeals for the First District of Florida and the Circuit and County Courts of Leon, Gadsden and Pinellas Counties, Florida.